A Comparison of School Refusers' and School Attenders' Attachment Relationships to their Main Care Givers and Peers

By
Charlotte Flack-Hill

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Department of Psychology
School of Human Sciences
University of Surrey

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Introduction to the Portfolio

This portfolio contains summaries of clinical work as well as academic and research work completed during the PsychD in Clinical Psychology. It is divided into two volumes.

Volume 1
This volume consists of three dossiers: academic, clinical and research. The academic dossier contains four essays, the clinical dossier includes summaries of five case reports and summaries of the six clinical placements. The research dossier consists of the service related research project, a research logbook and the major research project.

Volume 2
This volume contains five clinical case reports. This volume also includes logbooks of clinical experience gained, contracts, placement summaries, correspondence written and evaluation forms from each placement. This volume will be kept in the Psychology Department at the University of Surrey because it contains confidential material.
Academic Dossier
Compare and Contrast the evidence base for two theoretical models of Eating Disorders. What implications does this have for the Delivery and Provision of Clinical Services for People with Eating Disorders?
This essay will compare and contrast the evidence base for two theoretical models of eating disorders. The models discussed are the cognitive behavioural model and the systemic model because evidence suggests that both are effective in the treatment of eating disorders. Each model will be briefly described. Two types of evidence will be examined for each model: theoretical evidence for the model itself and clinical evidence concerning treatment efficacy of these models in practice. Conclusions drawn from comparing and contrasting the evidence has implications for the delivery and provision of clinical services for people with eating disorders will be discussed. Firstly, attention will be given to the definition and demographics of eating disorders.

What are eating disorders?
There are four classifications of eating disorder in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1994). They are bulimia nervosa, anorexia nervosa, binge eating disorder, and eating disorder not otherwise specified. Despite the clinical importance of all these disorders, this essay focuses on anorexia and bulimia nervosa. Inclusion of the other eating disorders would be beyond the scope of this essay.

The DSM-IV describes the diagnostic criteria for these two eating disorders as follows:

Bulimia Nervosa is characterised by:
1) Recurrent episodes of binge eating, with a lack of control over eating behaviour during eating binges.
2) Together with a preoccupation of body size, other associated features often include; self-induced vomiting, use of laxatives or diuretics, strict dieting and excessive exercise.
3) A minimum of two binge-eating episodes of a week over a period of three months are required to make this diagnosis.
4) Persistent self-evaluation linked to ideas about body shape and weight.
Anorexia nervosa is characterised by:

1) A refusal to maintain a minimally “normal” body weight. This is defined as a body weight which is 15% lower than average for the individual’s age and height.

2) There must also be an intense fear of becoming fat, even though underweight. This is accompanied by a severe restriction in food intake, and sometimes excessive exercising.

3) Disturbance in the way in which one’s body shape, size, or weight is experienced, and an undue influence of body shape on self-evaluation.

4) Amenorrhea in postmenarchal women.

The nature of eating disorders.

Eating disorders can be difficult to treat due to their complexity and common concurrent psychopathology. The median duration of anorexia nervosa is six years (Treasure & Kordy, 1998, cited in Bell, Clare and Thom 2001). Psychotherapy for anorexia is usually required for a year but it may be up to six years (APA Guidelines, 2000). However, morbidity in anorexia nervosa is higher than in any other psychiatric disorder (Nielson et al. 1998, cited in Bell Clare & Thorn 2001). For these reasons it is important to engage in evidence-based practice.

Early onset, during adolescence, is common in anorexia and bulimia. Most of the research has been conducted on women. According to Bramon-Bosch, Troop and Treasure (2000) research can be applied to males since their experiences of eating disorders are very similar to females.

The Cognitive Behavioural Model Of Eating Disorders

Background

The origins of Cognitive Behavioural Therapy (CBT) for eating disorders can be traced back to Beck’s (1967, cited in Hawton, Salkovskis, Kirk and Clark, 1989)
cognitive approach for depression. Beck proposed that negative thinking played a central role in the maintenance of depression and that these thoughts needed identification and modification. With the success of Beck’s work, cognitive therapy gradually merged with behaviour therapy into the model of ‘cognitive behaviour therapy’ (CBT).

**Cognitive Behavioural Model of Anorexia Nervosa and Bulimia Nervosa**

Garner and Bemis (1982) developed a cognitive behavioural model for AN. Fairburn, Cooper and Cooper (1986) developed a CB model for bulimia nervosa. CB models have tended to stress the close correspondence between the belief systems of anorexics and bulimics (Fairburn & Garner, 1988 cited in Vitousek, 1996), suggesting that the superficially dissimilar symptom patterns of these two client groups are traceable to an excessive reliance on weight and shape as bases for self-evaluation (Vitousek, 1996).

Vitousek (1996) has summarised the account in the following way:

“Reduced to its essence, the cognitive-behavioural model holds that anorexic and bulimic symptoms are maintained by a characteristic set of overvalued ideas about the personal implications of body shape and weight. These attitudes have their origins in the interaction of stable individual characteristics (such as perfectionism, asceticism, and difficulties in affect regulation) with socio-cultural ideals for female appearance. Once formed, the beliefs influence the individuals who hold them to engage in stereotypic eating and elimination behaviours, to be responsive to eccentric reinforcement contingencies, to process information in accordance with predictable cognitive biases, and eventually, to be affected by physiological sequelae that also serve to sustain disordered beliefs and behaviours.” (Vitousek, 1996, p.384).
Theoretical Evidence For The Cognitive Behavioural (CB) Model

Theoretical evidence on anorexia and bulimia has been grouped together since the CB claims that there is a close correspondence between the belief systems of anorexics and bulimics. Research on the CB model mainly consists of assessment of self-statements and beliefs and assessment of schematic processing.

Assessment of self-statements and beliefs
Cooper and Bowskill (1986, cited in Vitousek, 1996) investigated the relationships between daily events, hunger, affect and cognition in the binge-purge cycle in BN. Their results indicated that negative mood states preceded the binge-purge cycle. Self-statement inventories verified that anorexics and bulimics have characteristic irrational ideas about the magical properties of food and the implications of body weight (Vitousek, 1996).

Whilst these studies lend support to the CB model’s assumptions that cognitive content plays a large part in the maintenance of anorexic and bulimic symptoms, this research fails to address a number of methodological and conceptual issues (Vitousek, 1996). For example, the self-report measures used may be vulnerable to bias and distortion because anorexics are often keen to preserve egosyntonic (protected) symptomatology and therefore deliberately falsify information (Vitousek, 1996). Vitousek (1996) also argues that starvation may mean that anorexics have diminished capacity for thought abstraction and may have impoverished thought content.

Self-statement measures are not usually designed to test hypotheses about specific aspects of the CB model (Vitousek, 1996). Furthermore, assessment of self-statement only tells us about content of thoughts, which is not in dispute. It may be more helpful to investigate the development of beliefs held by anorexics and bulimics and how these beliefs affect their lives (Vitousek, 1996).

Assessment of schematic processing.
Cognitive processing paradigms overcome some of the weaknesses of the assessment of self-statements and beliefs. They employ test strategies that participants are unable
to decode and they minimise dependency on self-report. Cognitive processing paradigms explore the process through which beliefs develop, proliferate and become autonomous (Vitousek, 1996).

The Stroop paradigm (Stroop, 1935 cited in Vitousek, 1996) has been used to demonstrate the interface in information processing caused by schema-based conflict or anxiety. Research by Channon, Hemsley, & de Silva, (1988) with anorexic participants and research by Wilson (1989) with bulimic participants has shown that both groups manifest delayed response times when asked to name the ink colours of food and/or weight-related word sets relative to normal participants and relative to their own responses when neutral stimuli are presented. These results indicate that people with eating disorders have an attentional bias toward threatening stimuli. Elaborated fear structures associated with focal concerns require more cognitive processing capacity and thus compete with the cognitive processing capacity for colour naming (Foa, Feske, Murdock, Kozak, & McCarthy, 1991 cited in Vitousek, 1996).

However, the Stroop experiments do not rule out the possibility that hunger or chronic depression are responsible for disruptions in processing (Vitousek, 1996). Channon & Hayward (1990) confirmed that normal participants also show delayed processing times when the food Stroop is administered after a twenty-four hour period of fasting.

The hypothesised bi-directional relationships between affective states and weight perception or eating behaviour, of the CB model have been assessed through mood induction studies. Taylor and Cooper (1992) found that negative mood induction in a normal sample led to greater over-estimation of body size and greater body dissatisfaction. This effect was most pronounced in those with higher levels of shape concern.

In summary, self-statement inventories have indicated that anorexics and bulimics have characteristic irrational ideas about the magical property of food and the implications of body weight. However, self-statement research has been criticised for being methodologically flawed. Cognitive processing paradigms, such as the Stroop
paradigm have, in some cases highlighted attentional biases of anorexics and bulimics. Mood induction studies have provided support for the hypothesised bi-directional relationships between affective states and weight perception or eating behaviour, of the CB model.

Clinical Evidence Base For The CB Model

The term ‘clinical evidence’ is used to refer to empirical findings for the effectiveness of a certain model in the treatment of a particular disorder. It can be argued that randomised control trials frequently used to assess the clinical effectiveness of CBT and recently family therapy, are more rigorous and scientific than some of the theoretical research discussed in this essay. Research into bulimia will be considered first, followed by research on anorexia.

Clinical evidence for the CB model of BN

The application of the CB model is known as cognitive behavioural therapy (CBT). CBT has become the gold standard treatment approach for BN to which other psychotherapies are compared (Wilson, 1989).

CBT for BN was initially described by Fairburn (1981), further developed by Fairburn (1985) and Fairburn, Marcus and Wilson (1993). Fairburn et al. (1991) investigated the comparative effectiveness of three psychological treatments for bulimia: behavioural therapy, cognitive behaviour therapy, or interpersonal therapy. All three treatments had an equal effect on the frequency of overeating, the severity of the general psychiatric symptoms, and the level of social functioning. However, CBT is reported to have had a superior effect on concern about weight and shape than either of the other two approaches. CBT also produced greater reductions in the frequency of vomiting than the interpersonal approach (Fairburn, et al., 1991).

Limitations of the findings

Patients assigned to the CBT group in the Fairburn, et al.1991 study purged more frequently at outset than those who received IPT. Consequently, CBT cannot strictly
be compared to IPT in its management of vomit reduction. The initial frequency of this symptom may have provided the patient a more tangible measure of their 'improvement' after a number of therapy sessions, which may have contributed to increased motivation and hence further facilitated positive outcomes.

Another weakness of this study concerns patient characteristics, since only 88% of the participants met the DSM-III-R criteria for BN. Several had met the DSM-III-R diagnostic criteria for other eating disorders in the past. Many had received treatment for other psychiatric problems, misused alcohol, or took illegal drugs. It is possible that these personal characteristics affected treatment outcomes.

At follow up, a year later (Fairburn, Jones, Peveler, Hope, and O'Connor, 1993), participants treated with IPT continued to make improvements and had similar scores to those in the CBT group on all outcome measures. Five years later, (Fairburn et al. 1995) 37% who were treated with CBT and only 28% of those treated with IPT still had a DSM IV eating disorder. These findings may have important implications for the effective treatment of bulimia, as, unlike CBT, the method of IPT enhanced treatment gains without addressing food or weight issues directly. Furthermore, the reported differences in the temporal pattern of improvement between CBT and IPT suggests that each treatment operates through different mediating mechanisms to achieve its goals.

**Clinical evidence for the CB model of AN**

Channon, de Silva, Hemsley, and Perkins (1989) conducted a controlled trial for AN in which CBT was compared with behaviour therapy and 'treatment as usual'. CBT was not superior to other types of treatment. Whilst all groups improved, no group was clinically recovered when the study period ended.

**Limitations of the findings**

A number of methodological flaws make it difficult to draw clear conclusions from the Channon et al. (1989) trial (Vitousek, 1996). For example, the sample size was

The scarcity of clinical evidence for CBT in the treatment of anorexia. According to Vitousek (1996) there are a number of practical reasons for the lack of research evidence for the effectiveness of CBT in the treatment of anorexia. The longer recommended course of therapy for anorexics is reported to increase the likelihood of attrition, resulting in publication problems. Vitousek (1996) also expressed concerns regarding the difficulties in formulating the therapeutic task for later phases of intervention. This may be due to the fragile alliance between clients and psychologists as observed by Macleod, (1982; cited in Vitousek, 1996). These relational issues are considered to be of great importance to systemic therapies.

The Systemic Model Of Eating Disorders

Background
The systemic model assumes that neither symptoms nor insight can be appropriate focus for treatment interventions. The target of intervention is the system that generates the problem (Roth & Fonagy, 1996). The approach is most commonly applied to the system of the family, where each family member is seen as a unit of the system whose malfunctioning generates the client’s problem behaviour (Roth & Fonagy, 1996). In this essay the terms ‘family’ and ‘systemic’ therapies shall be used interchangeably.

The Systemic Model of Anorexia Nervosa and Bulimia Nervosa
There is considerable overlap in the different family systems accounts of eating disorders (Eisler, 1995). Due to the limitations of this essay, the author will concentrate on evidence for Minuchin et al’s (1975) and Minuchin, Rosman & Baker (1978) model.
Minuchin et al. (1975 and 1978) developed a model of the “psychosomatic family” of which they thought anorexia nervosa was a prime example. The model had three factors. Firstly, that the child is physiologically vulnerable. Secondly, that the child’s family has four transactional characteristics: enmeshment; over-protectiveness; rigidity and lack of conflict resolution. Thirdly, the child plays an important role in the family’s pattern of conflict avoidance and the role is an important source of reinforcement for his/her symptoms.

Theoretical Evidence For The Systemic Model
Attempts to empirically verify the “psychosomatic family” focus on the four transactional features of the psychosomatic family, possibly at the exclusion of the other two factors of the model. Research mainly consists of observational studies and self-report accounts of families.

Self-report accounts
Questionnaires such as ‘The Family Environment Scale’ (FES) (Moos & Moos, 1981 cited in Eisler, 1995) have been used in studies of family functioning in eating disorders (Eisler, 1995). There has been considerable variation in findings across studies (and between families within studies) using these questionnaires (Eisler, 1995). Le Grange (1989 cited in Eisler, 1995) and Dare, Le Grange, Eisler & Rutherford (1994, cited in Eisler, 1995) found participants report a lower level of closeness than they would like. This does not support Minuchin et al.’s (1975, 1978) claim that “psychosomatic families” are enmeshed. Waller, Calam and Slade (1989) found participants reported that communication and affective expression is restricted. This does appear to support Minuchin’s (1975,1978) notion that there is a lack of conflict resolution within eating disordered families (“psychosomatic families”).

However, questionnaires provide a limited and usually one-sided snapshot of the family (Eisler, 1995). A consistent finding with different questionnaire methods is that the differences that are found may apply only to selected clinical samples (Eisler, 1995). Community-based samples or studies that have controlled for factors such as
depression find little or no differences between the eating disordered groups and controls (Eisler, 1995).

**Observational studies**

In eating disorders, Expressed Emotion (EE) in families has been shown to predict response to treatment and the subsequent course of illness (Szmukler, Eisler, Russell & Dare, 1985) and that levels of EE are reduced after successful family treatment (LeGrange, Eisler, Dare & Russell, 1992). The EE scale is a reliable measure and consists of five subscales: critical comments; hostility; emotional over-involvement (EOI); warmth and positive remarks. Szmukler et al., (1985) and Le Grange, Eisler, Dare and Hodes (1992) have shown that the scales discriminate between families of anorexics and families of bulimics.

In families of anorexics, the levels of EE are generally low, with few critical comments and hostility is rare (Le Grange, Eisler, Dare & Hodes 1992). EOI is low while warmth is rated as moderate and few positive remarks are made. The low levels of criticism supports Minuchin’s (1975; 1978) lack of conflict resolution. However, higher levels of criticism present in bulimia and chronic illness (Szmukler, et al. 1985). Szmukler et al. (1985) reported low levels of EOI in families of bulimics.

Humphrey (1992, cited in Eisler, 1995) found the families of bulimic children enmeshed in a hostile, rigid pattern combining issues of attachment and autonomy. She claimed that anorexic families appeared less overtly hostile but instead communicated through a mixed message of loving affection with control or negation of the daughter’s needs to separate. Whilst these findings appear to lend support for Minuchin’s model, Eisler (1995) highlighted that although family interaction in eating disorder families may differ from control families, such differences should not in themselves be seen as pathological or pathogenic.

In summary, there appears to be support for Minuchin’s (1975; 1978) four transactional features of the psychosomatic family. However, the self-report accounts and observational studies that make up this evidence base have weak methodology
and therefore the notion that there is a particular type of family constellation or style of family functioning in anorexia and bulimia is unsustainable. Eisler (1995) suggested that observed differences between clinic-based and community-based samples indicates that observed family dynamics may be associated with a more chronic illness. These dynamics might not be disorder-specific, but characteristic of any family struggling with a life-threatening or chronic illness. Other observed similarities may be due to the developmental stage of the family life-cycle, where all families at this stage will be dealing with specific issues such as individuation/separation, the children leaving home (Eisler, 1995).

**Clinical Evidence for the systemic model of AN**

In a follow up study of 52 adolescents with anorexia, Minuchin et al. (1978) reported a good outcome in 80% of cases. The efficacy of a structural approach in the treatment of anorexia has been supported by a number of other controlled treatment studies (Russell, Szmukler, Dare & Eisler, 1987).

More recently, Dare, Eisler, Russell, Treasure and Dodge (2001) have demonstrated the treatment efficacy of family therapy (FT) for AN. Their randomised control trial was designed to assess effectiveness of specific psychotherapies in out-patient management of adult patients with AN. Eighty-four patients were randomised to four treatments:

a) One year of focal psychoanalytic psychotherapy.
b) Seven months of cognitive-analytic therapy (CAT).
c) Family therapy (FT) for one year.
d) Low contact, 'routine treatment' for one year (control).

There was a modest improvement across the groups. FT and psychoanalytic psychotherapy were superior to the control treatment and CAT showed some benefit.

**Limitations of the findings**

Dare et al (2001) report having a smaller sample than planned and a larger than expected number of participants in the study had a poor prognosis, and gained only limited benefit from the treatments. This reduced the power of the study to identify
differences between the three psychotherapies. Therefore, the conclusions have to be tentative.

Clinical Evidence for the systemic model of BN

The Maudsley studies, like other clinical research (cited in Dare and Eisler, 1995) have failed to provide a clear picture of systemic treatment efficacy for BN. The first Maudsley study showed FT to have a poor outcome for bulimics, those who received individual supportive therapy had an overall better outcome at five year follow-up.

Fairburn, Jones, Peveler, Hope & O’Conner (1993) and Fairburn et al (1995), (mentioned earlier in the ‘empirical findings in the ‘clinical evidence for the CB model of BN’ section), investigating the effectiveness of three psychological treatments for BN: behaviour therapy; CBT or IPT (interpersonal therapy) found IPT to be most effective at five year follow-up. This finding may have interesting implications for the systemic model. Jenkins and Asen (1992) stated that systemic therapy is not reliant upon the amount of people being seen, but refers to the theoretical framework adopted in therapy. As in the case of IPT, the systems concept of “family therapy without the family” (Jenkins & Asen, 1992, pp.1) focuses on creating new connections between different patterns of relationships for the client. In IPT therefore, although the patient is being seen individually, as with the CBT approach, the focus of treatment is more context related, rather than specifically focusing on food or weight issues. Fairburn et al.’s research indicates the significance of contextual factors, and implies that although they may take longer than CBT to become effective, systems theory and IPT models are effective in the treatment of bulimia.

Effectiveness of the approaches within different sub-groups

Russell, et al., (1987, also known as the first Maudsley study), conducted a control trial comparing FT with individual supportive therapy in AN and BN. After one year of psychological treatment they were assessed using body weight, menstrual function and ratings on the Morgan and Russell scales for AN and BN (Moragn and Russsell,
Adult Mental Health Essay

1975). FT was found to be more effective than individual therapy in patients whose illness was not chronic and had begun before the age of nineteen. There were no obvious benefits of FT for those with BN. These findings were confirmed in a five-year follow-up study (Russell, Dare, Eisler & Le Grange 1992, cited in Dare and Eisler, 1995).

Russell, et al. (1987) claimed that the FT probably helped the parents to overcome their sense of failure as they regained some control over their child’s eating behaviour and helped them to recover. Clinical impressions were that communications between the parents improved, and difficult issues, such as the gradual separation of the ‘child’ from the family became more comfortable to discuss.

However, Russell et al. (1987) reported that using a family systems approach is not as effective as an individual approach for the older clients. The authors explained that this may have been because the patient has “relative inaccessibility” (p.1055) to their parents’ efforts, hence minimising the therapeutic effect.

**Compare And Contrast The Evidence Base For The Models**

Research in both CBT and systems approaches have often relied upon self-report measures. According to Vitousek (1996) these measures are vulnerable to bias and distortion with the anorexic population for a number of reasons. As mentionned earlier, information on the measures may be falsified. Alternatively, a tendency towards over-compliance may also bias the outcomes. Diminished capacity of cognitive processes as a result of long term under-nourishment (Garner, Rockert, Olmsted, Johnson, and Cosicina, 1985; cited in Garner and Garfinkel, 1997) may also affect the accuracy of the anorexics’ responses.

Also, measuring effectiveness solely on the alleviation of symptoms is not acceptable in respect to FT (Orbach, 1985, cited in Dodge, Hodes, Eisler, and Dare, 1995). Although symptom changes in the eating disorders are often associated with psychological well being and social adjustment (Dodge, et al., 1995), it is important to investigate changes in family relationships. Scales such as the Morgan Russell Scale
are often used to assess these factors. However, self-report bias may not be eliminated.

Bearing these criticisms in mind, one can tentatively conclude that the CB model appears to have a slightly more substantial theoretical evidence base than the systemic model. The CB model appears to be more effective in treating BN, older people and people with more chronic problems. The systemic model appears to be more effective in treating AN in people with early onset and less chronic disorders.

**Implications For The Delivery And Provision Of Clinical Services To People With Eating Disorders**

Having compared and contrasted the evidence base for two theoretical models of eating disorders, recommendations for evidence based practice, in terms of the most effective means of treatment (delivery) and the supply of treatment (provision) can be made.

**Implications for the provision of services for people with BN.**

Numerous randomised control trials have shown that CBT is the treatment of choice for BN, and is more effective than medication in improving disturbed attitudes towards weight, shape and restrictive dieting (Bell et al, 2001). Although other therapies such as Interpersonal Psychotherapy (IPT) may have equivalent outcome (Fairburn et al., 1995), CBT remains the treatment of choice because it has a significantly faster impact (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000).

CBT for BN can be delivered in a self-help format (Hay & Bacaltchuck, 2000). Specialists have suggested protocols for the sequential treatment of bulimia nervosa (Treasure, Troop & Ward 1996). Andrews (1996) found a computerised programme helpful. Despite the efficacy of CBT, a significant number (up to 40%) do not respond successfully (Bell et al, 2001). Further research is needed to see how these patients can be helped (Bell et al, 2001). A significant subgroup of clients have other
problem behaviours such as substance misuse or self-harm and require more treatment (Bell et al, 2001).

Group approaches are also beneficial and more cost-effective (Fettes & Peters, 1992), though this may be less appealing to patients and drop-out is usually higher.

**Implications for the provision of services for people with AN.**

Family interventions are paramount and have better outcome than individual therapy for the treatment of AN in those under nineteen (Robin et al 1999). Wilson and Fairburn (1998) report that it is not necessary to treat the whole family, and outcome may be better if the parents are seen separately (Eisler et al., 2000, cited in Bell et al., 2001). Outcome is better in adolescents than those with later onset (Steinhausen, Boyadjieva, Grigoroiu-Sebanescu, Seidel, & Winkler Metzke, 2000, cited in Bell et al., 2001), but may be poor in those who are treated as in-patients (Gowers, Weetman, Shore, Hossain & Elvins 2000 cited in Bell et al., 2001).

Those with chronic AN, accompanied by depression or personality disorder will need support from generic psychiatric services (Bell et al, 2001). Mothers with anorexia nervosa should be encouraged to remain in treatment, having the welfare of their children monitored and help provided where necessary (Russell, Treasure and Eisler, 1998).

**Implications for the provision and delivery of services for children and young people with eating disorders.**

The Health Advisory Service (1995) reported that children and young people with eating disorders require separate provision from adults in a setting in which their broader developmental needs are understood and met. The Health Advisory Service recommended management of children with AN by a paediatrician because of the risk of stunted growth. Treatment should be as close to home as possible so that families can maintain links and be involved in treatment (Bell et al, 2001). Gowers et al (2000,
cited in Bell et al. 2001) highlights the need for effective community treatment, suggesting that in-patient treatment has adverse effects on young people.

**Implications for the provision of clinical services for people with eating disorders.**

Given the risk of chronicity, associated disability or morbidity (Health Advisory Service, 1995), and the challenges involved in treating those with eating disorders, specialist services are recommended (Robinson, 1998: Palmer, Gatward, Black & Park 2000).

The American Psychiatric Association recommend that psychotherapy may be needed for at least a year and that total length of treatment might be up to six years (APA Guidelines, 2000). Palmer et al (2000) therefore recommend that services for people with anorexia nervosa need to plan for prolonged contact and high rates of service consumption.

Specialist services need to educate health and psychiatric professionals to promote early detection (Bell et al 2001). They also need to have easy access with minimum hurdles in order to avoid repeated assessments. Close links between specialist and generic mental health services are essential because people with eating disorders frequently have other mental health problems too (Robinson, 1998: Palmer et al. 2000).

However, if protocols for the sequential treatment of BN (Treasure et al., 1996) can be used or a computerised programme (Andrews 1996), do we need a specialist service? Garner and Needleman (1992) describe a service has specialist co-ordination and provision for patients needing intensive or complex treatment, but protocols for initial treatment provided either in primary or secondary care. However, there is no one correct model of how services should be delivered as they will vary according to local need and personnel (Bell et al. 2001).

Should clients be treated as in-patients? Meads, Gold and Burls (2001) report that there is no evidence that inpatient treatment is more or less effective than outpatient
treatment for people with AN in the long term. However, short-term emergency admissions may be necessary. Bramon-Bosch et al., (2000) reported that males with an eating disorder show a stronger psychiatric co-morbidity and a higher rate of suicide attempts. It could be argued that males should therefore be considered for admission at higher weights than females.

In-patient and out-patient services should include assessment and treatment of AN and BN. A psychiatrist needs to monitor medication and other concurrent psychiatric disorders (Bell et al. 2001).

**Conclusion**

The evidence base for the systemic model and the cognitive-behavioural models are mixed. Theoretical and clinical research of these models has been problematic, due to weakness in their methodology. However some conclusions can be drawn which inform evidence-based practice. Outcome studies indicate that CBT is the treatment of choice for bulimia nervosa. Little research has been conducted on CBT for AN, mainly for practical reasons such as increased likelihood of attrition due to the longer course of therapy. This has created problems for publication. In those with early onset, family therapy is recommended and in those with a later onset couples therapy (which can also be from a systemic perspective) is recommended. A third model, from a psychodynamic orientation, has also been shown to be helpful when applied for treatment, Interpersonal therapy (IPT) in the treatment of BN. This however, is beyond the scope of the essay which has compared and contrasted the evidence base of two theoretical models and considered the implications for the provision and delivery of clinical services for people with eating disorders.
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Critically Review the Current Status of the Assessment and Treatment of Dementia in Adults with Learning Disabilities.

People with Learning Disabilities Essay

Year 1

July 2002
Introduction

Recent increases in life expectancy mean that people with learning disabilities are developing conditions associated with older age, which are a new phenomenon for this group. One of these age-associated conditions is dementia. This essay aims to critically explore the current assessment and treatment strategies for people with a learning disability and dementia.

Firstly the concepts: learning disability, dementia and dementia in people with a learning disability will be described. This essay will focus on progressive and irreversible dementia. Secondly, issues of assessment such as processes leading to referral and differential diagnosis will be highlighted and alternative methods of assessment will be critically discussed. A measure relating to each of the main diagnostic features of dementia will then be critically examined. In contemplating the current status of treatment in adults with learning disabilities, it will be argued that there is no treatment for dementia. Management and psychological interventions will be described. Strengths and limitations of the evidence base for these approaches will be highlighted. Finally, some concluding comments will be made.

Learning Disability and Down's syndrome

The term 'Learning disability' (LD) refers to those with an impaired intellectual functioning (IQ of 70 or less) accompanied by deficits in adaptive or social functioning with an onset before 18 years of age – Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) American Psychiatric Association (APA, 1994). A third of the learning disabled population have Down's syndrome (DS) (Janicki & Dalton, 2000). People with DS have an additional chromosome 21, seem to age prematurely and are therefore considered to be at greater risk of older-age associated health conditions such as dementia, specifically Dementia of the Alzheimer's Type (DAT) (Holland, 1999). Research into dementia in people with LD has often focused on people with DS because it is the most common cause of LD and because of its link with dementia of the Alzheimer's type. This is problematic and is explored later on.
Dementia

This essay will focus on irreversible and progressive dementia. The International Statistical Classification of Diseases and Related Health Problems (ICD10, World Health Organisation [WHO], 1992) criteria have certain advantages over others (Aylward, Burt, Thorpe, Lai & Dalton 1997). Firstly, it distinguishes Dementia of the Alzheimer's Type from other types of dementia. Secondly, it highlights non-cognitive elements of dementia, which are often the first noticed in persons with LD (Aylward et al. 1997). The ICD-10 criteria are: a decline in memory accompanied by decline in other cognitive abilities (such as judgement or planning), in the absence of "clouding of consciousness" (WHO, 1992). Furthermore, there needs to be a decline in emotional control, motivation or social functioning and these symptoms need to have been present for at least six months (WHO, 1992). For a diagnosis of Alzheimer's disease, in addition to these criteria, there must be a gradual onset with continuing cognitive decline and exclusionary criteria must be met ruling out other causes such as a "systematic" disorder, drug or alcohol abuse (WHO, 1992).

Dementia has been characterised as having three stages: early, mid and late stages (Janicki, Heller, Seltzer & Hogg, 1996). The early stage typically involves difficulty finding words; loss of interest in previously enjoyed activities and memory loss and forgetting routines (Janicki et al. 1996). The middle stage is characterised by: a significant decline in language skills demonstrated by an inability to have a coherent conversation; decline in self care skills and continence; further memory loss; paranoia and delusions; late onset seizures and frustration (Janicki et al. 1996). In the late stage the following skills and abilities are lost: eating and drinking which leads to weight loss and dehydration; maintenance of balance and walking; long and short term memory; recognition of familiar people and environment (Janicki et al. 1996).

Dementia in persons with LD

Aylward and colleagues (1997) report on the lack of standard diagnostic criteria and procedures for dementia in persons with LD. There is no dementia definition specific to individuals with LD. The presentation of dementia, in terms of type and rate of
dementia, symptoms and duration is very similar in those with LD (with the exception of adults with DS), as it is in the general population (Janicki & Dalton, 2000). However, the presentation of dementia in people with DS is different from these two groups (Janicki & Dalton, 2000).

People with DS tend to be affected by dementia at a younger age than people with other types of LD and the general population (Alvarez, 1996). Whilst memory loss is one of the first symptoms of dementia to be experienced in the general population, for people with DS the first signs tend to be a need for more assistance with self-help skills (Lai & Williams, 1989).

Only a third of the LD population have DS (Janicki & Dalton, 2000). Whilst 75% of people with DS and dementia have dementia of the Alzheimer's type (DAT); only 27% of the non-DS LD and dementia population have DAT, the remaining percentage have other types of dementia. Research that only focuses on people with DS and AD is therefore only representative of approximately a quarter (0.33 x 0.75) of people with LD and dementia. Research conducted on the general population may be more applicable to people with non-DS LD than to those with LD. However assessment tools used in the general population are inappropriate for use in the LD population (Holland, 1999).

**Assessment**

In order to benefit from psychological interventions, clients need to initially be assessed. Assessment is also important in identifying clients who could take part in research to further our understanding of dementia in people with LD.

**Processes leading to referral**

A three-stage approach for dementia care has been described by Janicki et al. (1996). This requires: 1) recognition of changes through developing staff knowledge; 2)
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assessment and evaluation of those changes and diagnosis and 3) installation of appropriate care-management and medical strategies.

In order to be referred to services, care-workers and carers of individuals with LD need to be able to detect a change in the client and be aware of the possible signs and symptoms of dementia onset. Research by Whitehouse, Chamberlain & Tunna (2000) found care staff workers in houses for people with LD to have limited knowledge of ageing and incorrectly judged forgetfulness to be a first sign of dementia (Lai & Williams 1989).

High staff turnover and use of agency staff in LD services may mean that staff do not know clients well enough or for long enough to notice symptoms of dementia (Oliver, 1999). The "care culture" of LD services often results in the environment being adapted to meet the needs of the client, thus hiding any loss of cognitive function (Oliver, 1999). Cognitive decline can sometimes be attributed to the existing LD or part of the normal ageing process (Holland, 1999). These problems highlight the need for staff training on dementia (Whitehouse et al. 2000). Whitehouse et al. (2000) reported that staff lacked confidence in their ability to help clients diagnosed with dementia which may explain the high level of staff burnout. As well as a training programme, Whitehouse et al. (2000) piloted an induction pack for care staff. It seems then that attempts are being made to help care staff detect possible symptoms of dementia and refer them for assessment.

Differential Diagnosis

Differential diagnosis is essential because people with DS are vulnerable to other disorders such as depression and hypothyroidism which can hide or mirror the early symptoms of dementia (Holland, 1999). Many of these other disorders are treatable, for example, treating hypothyroidism can lead to gains in cognitive functioning (Thase, 1982).

Baseline functioning is more heterogeneous in the LD population than in the general population and it is therefore inappropriate to use measures of dementia developed for
the general population in people with a LD (Holland, 1999). Persons with LD need to experience a change "from their baseline functioning, rather than from a 'normal' level", in order to be diagnosed with dementia (Burt & Aylward, 1999 p.144). This requires assessment of cognitive functioning before the age of fifty in adults with LD and before forty in adults with DS (Burt & Aylward, 2000). Ideally cognitive functioning should be re-assessed once every 1-5 years, so that as soon as declines are suspected and cognitive functioning is re-assessed, more accurate estimations can be made about the timing of dementia onset (Burt & Aylward, 2000). This can aid early and precise diagnosis and care planning (Burt & Aylward, 2000).

Methods of Assessment
There is no gold standard for assessment (Oliver, 1999). The extreme and varied cognitive profiles of those with severe LD can make assessment for dementia difficult (Oliver & Holland, 1986). Assessment tools used in the general population frequently yield floor effects when used on those with LD (Oliver, 1999). There are a variety of approaches to assessment, the discussion that follows will focus on the retrospective and prospective methods and the use of direct and indirect tests.

Retrospective and Prospective
Retrospective assessment involves carrying out a full cognitive assessment. The clinician then goes back through their client's file notes, interviews with carers and reports. In doing this judgements are made about whether cognitive decline is due to dementia (Sims, 2002). Prospective assessment involves using dementia specific assessments on a regular basis and comparing results generated at each time of assessment (Sims, 2002). Prospective assessment is considered more reliable for various reasons (Oliver, 1999). For example, previous assessments drawn on in a retrospective approach are unlikely to include tests of early dementia symptoms and will probably be unable to pinpoint onset and rate of decline (Oliver, 1999). Prospective assessment therefore enables more effective care planning (Oliver, 1999).
Direct and Indirect
Since there is no gold standard assessment tool for screening dementia in people with LD (Oliver, 1999), the clinician needs to decide which assessment tools are most appropriate for their client. In making this decision, the clinician needs to consider the impact of the test on the client, as well as the reliability and validity of the test (Sims, 2002). Direct tests (those administered to the client) are not very reliable or valid (Oliver, 1999). Severe LD can make it impossible to carry out "language laden" cognitive tests (Oliver, 1999). Many direct tests require the client to answer three questions in succession incorrectly before the test is discontinued. This may have a negative impact on self-esteem (Oliver, 1999).

Informant based assessments are therefore used (Oliver, 1999). These assessments can be carried out more quickly and it is not necessary for the individual to participate (Oliver, 1999). However, the best informants (parents or family) may not be available. Other features of LD services such as high staff turnover and adaptive environments, (mentioned earlier in the "Processes leading to referral" section) also make informant-based assessments problematic (Oliver, 1999).

Test Battery
Burt & Aylward (2000) report the results of an analysis of assessment tools carried out by an international working group known as the American Association on Mental Retardation/International Association for the Scientific study of Intellectual Disability (AAMR/IASSID) Working Group. Clinicians were asked to identify the measures they considered to be the most valid, reliable and clinically useful for the assessment of dementia in the LD population, in order to develop a test battery. The battery includes eighteen tests, thirteen direct tests and five informant-based tests (Burt & Aylward, 2000).

This battery has not yet been evaluated (Dalton, Wisniewski & Janicki, 1999). However, it can be used to unify and standardise research and clinical practice, which will help further our understanding of dementia. Another criticism of the battery is that the tests have been developed in North America for individuals familiar with the
predominant English-speaking American culture (Burt & Aylward, 1998). Examiners who are testing individuals with LD in other countries or subcultures therefore need to modify instruments appropriately for their own use (Burt & Aylward, 2000). Burt & Aylward (2000) did not offer any guidance on how this might be done.

One test for each of the three main ICD10 criterion (for which there exist neuropsychological tests for a diagnosis of dementia) will be discussed.

ICD10, 1: Memory
These tests measure either verbal or non-verbal memory. Verbal instructions are frequently used in memory tests (Oliver, 1999). The individual’s ability to understand instructions may affect their performance and not give an accurate measure of their short-term memory (Oliver, 1999). Language problems may also affect performance on object memory and naming and word finding tests (Oliver, 1999).

*Dementia Questionnaire for Mentally Retarded Persons (DMR) (Evenhuis, 1992, 1996).*
This informant-based measure is designed to detect dementia in people with mild to profound LD. Although the test has been shown to be reliable, valid and to measure clinical change over time (Evenhuis, 1992, 1996), Prasher (1997) found it created excessive false positives in people with behavioural problems. However, this tool is the only short informant dementia scale providing normative data for adults functioning in the mild and moderate ranges of LD (Burt & Aylward, 1998). It also assesses orientation skills, which other brief scales do not (Burt & Aylward, 1998).

ICD10, 2: Other Cognitive Functions
The impact of cognitive decline on daily living can be assessed through the re-administration of adaptive behaviour scales such as the AAMR – Adaptive Behaviour Scale – Residential and Community edition (Nihira, Leland & Lambert, 1993 cited in Burt & Aylward, 1999). The Downs Syndrome Mental Status Examination (Haxby, 1989) and the Dementia Questionnaire for Mentally Retarded Persons (Evenhuis,
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1992, 1996) can be used to assess possible declines in orientation to person, time and place (Burt & Aylward, 1999).


The ABS-RC: 2 assesses independent functioning in ten domains (part one) and maladaptive behaviour in eight domains (part two). The scale does not provide clear guidance of scores required to make a clear diagnosis of dementia in an individual with LD (Deb & Braganza, 1999). These authors also argue that it is unclear whether a decline in score reflects normal ageing or the onset of dementia. Although the ABS was found to differentiate between groups with DS with no dementia and those with moderate to severe dementia, it did not differentiate between healthy individuals and those with mild to moderate dementia (Prasher, Chung & Haque, 1998)

**ICD10, 3: Awareness of Environment (Delirium)**

A clinical examination should be used to assess delirium in people with LD (Aylward et al. 1997). People with LD can be prone to delirium due to irregularities in their central nervous system (Lipowski, 1990 cited in Aylward et al. 1997) and may experience delirium as a result of pharmacotoxic reactions (Tuinier & Verhoeven, 1994 cited in Alyward et al. 1997).

**ICD10, 4: Emotional Control, Motivation or Social Behaviour**

Observed abnormal behaviour may be due to the individual’s LD, or it could be due to the onset of dementia. People with LD may be unable to describe the symptoms they are experiencing, or to appreciate that their abilities or mood have changed. The Reiss Screen for Maladaptive Behaviour (Reiss, 1987 cited in Burt & Aylward, 1999) (or others) can be used to assess the severity of the problem and whether the client appears to be suffering from a psychiatric disorder (Burt & Aylward, 1999). Any such psychiatric disorder can then be treated (Harper, 1993 cited in Burt & Aylward, 1999).
Reiss Screen for Maladaptive Behaviour (Reiss, 1987, cited in Burt & Aylward, 1999). Maladaptive behaviour needs to be screened because behavioural change can occur prior to cognitive change. Furthermore, maladaptive behaviours may be caused by treatable conditions such as depression (Burt & Aylward, 1998). Scoring yields a profile of possible psychiatric diagnoses. According to Aman (1991 cited in Burt & Aylward, 1999), the Reiss screen is the best screen for psychopathology in adults with a LD. Burt & Aylward (1998) have questioned the specificity of the diagnoses that are obtained, with particular concern about items on the depression scale. This scale is not designed to detect dementia and therefore psychopathology may be detected that is secondary to dementia, rather than indicative of a co-occurring psychiatric disorder (Burt & Aylward, 1998).

ICD10, 5: Duration
This can be assessed through a caregiver interview. It will obviously require the informant to have been caring for the client for over six months (Burt & Aylward 1999).

Summary
In order for assessment to take place an individual needs to be referred. Research has shown that due to certain aspects of LD services, care-workers may be slow to detect symptoms of dementia and therefore slow to make a referral (Whitehouse et al 2000). Differential diagnosis is essential because people with DS are vulnerable to other disorders whose symptoms mirror dementia, but are actually treatable (Holland, 1999).

There is no universally established assessment instrument for dementia in the LD population (Zimbleman & Wilson, 2000 cited in Sims 2002). The tools used to assess dementia in the general population are not appropriate for the LD population (Oliver, 1999). This is largely due to the heterogeneity of cognitive functioning within the LD population (Burt & Aylward, 1999). In the general population, individuals need to experience a change from the 'normal' level of functioning (Burt & Aylward, 1999).
Within the LD population prospective assessment is recommended (Oliver, 1999). The AAMR/IASSID guidelines recommend that individuals should have their cognitive functioning assessed prior to the onset of dementia (Burt & Aylward, 2000). The guidelines also state that cognitive functioning should be assessed at regular intervals so that the current and baseline functioning can be compared to identify decline (Burt & Aylward, 2000). The test battery produced by the AAMR/IASSID Working Group still needs evaluating but can be usefully employed as a means of unifying clinical and research-based assessment whilst further research is carried out. Further research is needed to identify a 'gold standard' by which to evaluate test results in order to determine which tests are most useful in detecting declines and what constitutes a clinically significant decline (Burt & Aylward, 1998).

Sims (2002) acknowledges the increase in life expectancy of those with LD and questions whether services are ready to cope with the greater number of LD clients who will need assessment and treatment for dementia. What is currently the most effective treatment for dementia?

**Treatment**

There is no treatment for progressive dementia. Thorough assessment may identify conditions that mirror dementia which are treatable, for example, depression. However, if progressive dementia is diagnosed, there are no treatments available as yet rather, care and medical management is adopted.

**Medical Management**

The research on medical management of dementia in the LD population is limited and therefore clinicians look to the general population practice for guidance (Arshad, Sridharan & Brown, 2001). Although there are no "cures" for dementia certain drugs have been found to slow down the progression of decline in DAT. For example,
donepezil hydrochloride has been recommended by the National Institute for Clinical Excellence (NICE) guidelines on the use of Donepezil, Rivastigmine and Galantamine for the treatment of AD (2001). The NICE report does not offer guidance on the use of these drugs with the LD population. It recommends these drugs for those with dementia scoring above 12 points on the mini-mental state examination (MMSE), a tool that cannot reliably be used with the LD population (Deb & Braganza, 1999 cited in Arshad et al. 2001). LD specialists may be put off prescribing these drugs as the guidelines do not appear to be appropriate for the LD population. However, Kishnani et al. (1999) reported positive results in the use of Donepezil in three people with DS and dementia.

Care Management
The AAMR/IASSID guidelines suggest that care management should involve helping preserve and maximise function, be stage-appropriate and multidisciplinary (Janicki et al. 1996). Early stage care practices should involve a continued sense of routine; aiding successful completion of daily activities thus boosting self-esteem and helping maintain muscle tone (Janicki et al. 1996). By the mid-stage care management includes safety adaptations to the environment as clients remain ambulant but have significant decline in cognitive functions such as orientation (Janicki et al. 1996). Continence maintenance also becomes important (Janicki et al. 1996). By this stage respite for carers becomes a crucial element of care management (Janicki et al. 1996). Late-stage care management involves 24-hour supervision and clients need help with all aspects of self-care. Family and carers will need help in coming to terms with the prospect of, and then actual, bereavement. Janicki & Dalton (1999) acknowledge that although these guidelines are helpful they lack precision. Further communication is needed to develop thorough care management practice (Janicki & Dalton, 1999).

Advice to Carers, Family and Professionals
Carers and care-workers need to be educated about 'normal ageing', dementia, the nature of the illness and the various stages it entails (Janicki et al.1996). This will aid early diagnosis. Carers and care-workers also need guidance on how to maintain the
individual's personal identity and pride (Janicki et al. 1996). This type of education and guidance is becoming increasingly available through the internet. For example, the Alzheimer's society (2000) have produced a very helpful information sheet that covers these issues and is available on-line.

Family carers should be made aware of alternative sources of professional support (Janicki et al. 1996). In particular, respite is essential for carers as it helps them to cope with the extreme levels of stress experienced in caring for someone with dementia. This also has the advantage of enabling the family to care for the individual within their home for as long as possible, thus maintaining familiarity and routine as recommended by the AAMR/IASSID working group.

Newroth & Newroth (1980 cited in Holland, Karlinsky & Berg, 1993) stressed the need for a supportive team-based approach amongst care staff in residential accommodation. Newroth & Newroth suggested that staff may need counselling (Holland et al. 1993). They also highlighted the need to explain to other residents that the individual with dementia is unwell and what the illness may entail (Holland et al. 1993).

**Psychological Interventions and Strategies**

In addition to the somewhat limited evidence-based care management some effective clinical strategies such as 'reality orientation' and life reviews have been developed (Prosser, 1989). Reality orientation has enhanced verbal orientation (Woods & Britton, 1985 cited in Prosser, 1989). Clinical strategies have also been described to help with sleep disturbance and to reduce agitation and confusion which are also common features in dementia (Vitello, Bliwise & Prinz, 1992). These include maximum activity and minimum rest during the day and effective bright lighting (Vitello et al. 1992).

Environmental features of a specialist accommodation for people with dementia and a LD have been described by Valios (2001). These features include special lighting to reduce puzzling shadows; having all toilet doors the same colour to help residents
recognise them and circular paths around the house to enable clients to walk safely through the garden. However, most residential facilities do not have such design features. In most cases clients are therefore moved to 'safer' environments as the dementia progresses. As a result clients are in less familiar surroundings and their social networks are disrupted. This goes against the AAMR/IASSID guidelines (Janicki et al 1996).

Service Planning
How should services provide for the increasing numbers of older people with learning disabilities? Janicki & Dalton (2000) stress the need for accurate information regarding prevalence rates of dementia, onset and duration of the illness for coherent service planning and development. Services need to be able to provide early and repeated assessments. They also need to be able to be ready to meet the increasing demands for professional care in the later stages of the illness (Janicki & Dalton, 2000). Bailey & Cooper (1997) reported that 96.3% of all NHS trusts in England and Wales which provide specialist health services for people with LD claimed responsibility for the provision of services to older adults with LD. However, research conducted by Cooper (1997) suggested that health and social care needs were poorly met for these older adults. Such services will be able to refine the care they provide by being better informed about population needs through research and clinical experience.

Valios (2001) claims that services are not yet adequately responding to the new needs of the learning disabled population. In the era of long stay hospitals staff were used to working with individuals up until they died (Valios, 2001). Since the closure of these hospitals individuals who would have been in-patients have been re-housed in community residential homes. Whilst this was essentially a positive move, staff in community homes are less experienced in dealing with individuals in the latter part of their lives within these settings (Valios, 2001). Consequently individuals are having to leave their familiar homes to move to older adult accommodation, even though they may only be 40 or 50 years old (Valios, 2001). This goes against the AAMR/IASSID guidelines.
Janicki & Dalton (1999) consider whether people with LD should share dementia care with the general population ('generalist care') or whether they should have care specifically for people with LD and dementia ('specialist care'). Janicki & Dalton (1999) argue that care management for people with dementia is very similar for people with and without LD and they therefore question the need for separate services. However, the authors acknowledge that "ageing in place" does not constitute the same experience for both groups. According to Janicki & Dalton (1999), "ageing in place" for the general population could either be care by the family or admission to a long-term setting but essentially involves a transition from 'independent living' to "being cared for". For people with moderate to severe LD there is no such transition, typically these people are cared for throughout their life and the onset of dementia necessitates more intense care and a change to their already existing care plan (Janicki & Dalton, 1999).

Janicki & Dalton (1999) discuss the implications of developing specialist services for people with LD and dementia and enabling people to "age in place". "Ageing in place" involves using services and making adaptations to the home to enable the individual to stay in the same accommodation despite changing circumstances such as the onset and progression of dementia. An individual is therefore more able to maintain his/ her social network, feel safe and avoid too much disruption and change. Valuing People (Department of Health, 2001) presents four key principles that should be the centre of any debate on LD services: rights, independence, choice and inclusion. Ageing in place can be seen as in keeping with all these principles, particularly inclusion aiding access to mainstream services. Re-accommodating individuals in specialist services could be seen as segregation in the same way as long-stay hospitals. Furthermore those moved into specialist services in the near future may recall very institutionalised care and readily fall into an institutionalised way of being (Janicki & Dalton, 1999).

Specialist services however may arguably provide more 'expert' care, particularly for those who would otherwise be living with their families. Carers may be very distressed by seeing their loved one decline through dementia and find it very stressful
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to have them at home. Similarly, other residents of those living in community homes suffering from dementia may become very distressed by changes in their co-resident (Janicki & Dalton, 1999). They may also feel that staff are less available to them because their co-resident with dementia demands more staff time and attention. Staff burnout as a result of caring for an individual with dementia in a non-specialist setting may inadvertently compromise the rights, independence and choice of those living in a community setting where one of the residents has dementia. However, if adequate resources are provided this should not be a problem. Given the increasing number of people with LD and dementia it is imperative that these issues are addressed imminently.

Conclusions

There appears to be an imbalance in the literature with greater emphasis being placed on assessment whilst treatment is less researched. Although the focus has been on assessment there still is no universally established assessment instrument for dementia in the LD population (Zimbleman & Wilson, 2000 cited in Sims 2002). This essay has highlighted current difficulties in the assessment of dementia in people with LD such as the lack of training currently available for carers and care-workers on 'normal ageing' and symptoms of dementia. This has meant that many individuals are not assessed until they are in the mid to late stages of dementia. Consequently they are unable to maintain their independence and quality of life as well as may have been possible had dementia been identified in the early stage. This essay has stressed the importance of differential diagnosis: people with DS are vulnerable to other disorders whose symptoms mirror dementia, but are actually treatable (Holland, 1999).

There is no 'treatment' for dementia in that no interventions can stop or undo the progression of dementia (Sims, 2002). Care management practice guidelines (Janicki et al 1996) are helpful but lack precision. Janicki & Dalton (1999) stress the need for professional communication and discussion in order to develop a comprehensive approach to care management practice. Psychological strategies such as 'reality orientation' and management of an individual's environment have also been found to
be effective in maintaining the best quality of life possible for adults with dementia. The current evidence base has not been established by academics but rather through individual agencies reporting real-life experiences (Dalton, Wisniewski & Janicki, 1999). Forward planning is crucial for individuals with LD. In particular consideration of issues relating to "ageing in place" should take place whilst an individual is in their early adulthood. Given the increasing numbers of adults with LD developing dementia it is imperative that increased resources are given to researching and developing services which aim to assess, manage and hopefully, one day, treat dementia in the learning disabled population.
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Is CBT appropriate or effective for children? If not, can it be made so?

Children, Adolescents and Families Essay

Year 2

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Introduction

CBT is an approach developed through work with adults (Stallard, 2002a). Research has shown that adult psychological problems can effectively be treated through CBT (Roth & Fonagy, 1996). Can this approach be appropriately and effectively applied to children?

This essay aims to critically explore the issues that pertain to the efficacy and appropriateness of using cognitive behavioural therapy with children. Firstly a brief overview of CBT will be given. A discussion on the appropriateness of engaging young people in CBT will follow. Theoretical, practical and ethical issues will be examined and suggestions on how these can be overcome, making CBT more appropriate for children, will be presented. In exploring whether CBT is effective for children, outcome research in the form of randomised controlled trials, meta-analyses and recent studies will be examined. The usefulness of this research when applied to the clinical setting will be critically discussed. The effectiveness of four key elements of CBT: thought control, self instruction, affective management and graded exposure will be reviewed and suggestions will be presented about how they can be made more effective for use with children. Finally, the material presented in the essay will be summarised in order to reach an overall conclusion.
An Overview of CBT

A brief overview of cognitive behavioural therapy will be given, focusing on elements of the approach relevant to the discussion that follows.

Beck (1979) claimed that distorted cognitions based on schemata (attitudes) developed in early life, predispose individuals to psychological difficulties. These schemata can trigger dysfunctional assumptions when faced with important events (Beck, 1979). For example, "I must be good at everything" (schema), may cause an individual to think, "I must practise my driving for four hours a day", when faced with a driving test. This assumption can lead to negative automatic thoughts such as "I must be stupid, I will never pass my driving test." These automatic thoughts can affect mood, behaviour and physiology.

CBT involves helping individuals recognise the relationship between cognition, affect and behaviour. Individuals are helped to challenge distorted thoughts and replace them with more realistic interpretations of these biased cognitions (Beck, 1979). Dysfunctional schema that predispose them to cognitive distortions and psychological difficulties are challenged and amended (Beck, 1979).

A range of techniques are used in CBT, some behavioural, others cognitive. Three techniques commonly used with children will briefly be described. Systematic desensitisation (Wolpe, 1958, cited in Rachman, 1997) requires anxious individuals to expose themselves to a hierarchy of feared situations in a graded way, either in vivo or in their imagination whilst relaxed. Modelling (Bandura, 1977 cited in Davison & Neale, 1998) enables an individual to learn through observing and replicating other's behaviour. Self-instructional training (Meichenbaum, 1975) teaches individuals to tell themselves what to do and how to cope with difficult or new situations.
The appropriateness of CBT for children

Appropriateness will be assessed in terms of theoretical, developmental and ethical considerations. In contemplating these considerations, suggestions will be made about how these difficulties can be overcome, making CBT more appropriate for use with children.

Why CBT is inappropriate for children

Three main reasons why CBT is inappropriate for children are presented. Firstly, CBT is inappropriate because its' theoretical basis and models of intervention are not based on children (Stallard 2002a). There are no developmentally appropriate theoretical models to explain the development and maintenance of maladaptive processes in children (Stallard, 2002b). Secondly, CBT is inappropriate for children because it is very sophisticated and complicated requiring abstract conceptual thinking, which many children do not have. Children do not develop the ability to think about their own thoughts (meta-cognition) until adolescence (Piacentini & Bergman 2001). Thirdly, CBT is inappropriate for children because it does not consider others within the child's system that may have played an important part in the onset and maintenance of the presenting problem (Berman, Weems, Silverman & Kurtines, 2000).

How CBT can be made more appropriate for children.

In order to establish the appropriateness of CBT for children, cognitive distortions and deficits, which characterise childhood psychological disorders, need to be observed (Spence, 1994). Furthermore research should also show that working therapeutically with these distortions and deficits will lead to changes in affect and behaviour (Spence, 1994).

Studies have shown children and adults with the same psychological disorder tend to suffer similar cognitive distortions and deficits (Spence, 1994). For example, cognitive deficits in planning and problem solving have been found in young people.
with Attention Deficit Disorder (ADHD) and interpersonal problems (Kendall, 1993, Spence & Donovan 1998, both cited in Stallard 2002b).

Cognitive distortions have been observed in children through research using the Stroop colour-naming task and the attentional dot-probe. This has indicated the attentional bias of anxious adults towards threatening stimuli. Martin et al. (1992 cited in Piacentini & Bergman, 2001) observed biased attention towards threatening words on a Stroop task in people as young as six years of age. Barrett, Rapee, Dadds & Ryan (1996) found anxious children were more likely to interpret ambiguous stimuli in a threatening way than non-anxious children and were even more likely to adopt avoidant coping strategies after discussing it with their parents. This highlights the influence of parents/careers, peers and teachers on the development and maintenance of dysfunctional cognitive processes (Stallard, 2002b).

The role and onset of cognitive distortions and deficits in children's problems have not been fully explained (Stallard, 2002b). It is unclear whether abnormal cognitive processing is associated with psychological problems and whether changes in mood and behaviour result from changes to cognitions in children (Stallard, 2002b). To make CBT more appropriate for children developmental variations in, for example, the way fear is manifested at different stages of childhood (Barrett, 2000) need to be considered and integrated in child models which can then inform CBT (Stallard, 2002b).

In relation to developmental concerns, Verduyn (2000) argued that children in the concrete operational stage (typically reached at between seven and twelve years of age) who can identify and describe thoughts in simple terms, establish goals and work with a therapist should be able to engage in CBT. It is questionable whether all adult clients can engage in abstract conceptual thinking, given that seven million adults in Britain have poor reading and maths skills (Government Office for the South East). If children are not very different from adults in this respect, perhaps CBT is appropriate for adults and children or inappropriate for both.
To make CBT more appropriate for children, abstract concepts need to be translated into simple, concrete understandable examples and metaphors that a child can relate to because they have experienced them in everyday life (Stallard 2002a). These issues will be explored further in a discussion around the effectiveness of CBT.

In relation to systemic and ethical issues, a child's system can be included in CBT to make it more appropriate for children. Teachers can be advised on particular difficulties and how to help the child cope with school and their peers. It may be appropriate for teachers to be involved in designing and carrying out behavioural management programmes during school time. Including parents in CBT can make it more appropriate for use with children (Stallard, 2002a).

Stallard (2002a) described a variety of roles that Parents have played in CBT with children, including: facilitator, co-therapist and client. As a client, a parent can be taught behaviour management, communication and problem solving skills and how to help the family be an ‘expert team’ in dealing with presenting difficulties (Barrett, 1998 cited in Stallard, 2002a). As a facilitator, a parent can help the child practise skills acquired in clinical sessions at home (Stallard 2002a). As a co-therapist a parent can help the child address difficulties in their use of cognitive skills. This raises a number of ethical issues. For example, it is questionable who gives consent to treatment, the child or parent(s) (Doe, Elsworth, Tingay & Wolpert, 2002). CBT is collaborative, objective and structured (Stallard 2002a). It is unclear whether the parent or child would decide on the goals for treatment (Doe et al. 2002). CBT is committed to minimal invasiveness but this may mean that underlying family dysfunctions are ignored (Doe et al. 2002).

Thus it appears as though including parents to make CBT more appropriate for use with children raises ethical concerns. However, Doe et al. (2002) argued that these concerns can be overcome if the clinician creates the right type of environment for therapy. An open environment in which conflicts about factors maintaining the problem, blame and the best way forward can be discussed between family members and therapist is essential (Doe et al. 2002). The clinician should be very open with the
family, sharing all formulations and sending them copies of all reports written about them (Doe et al. 2002).

Systemic therapy may be more appropriate than CBT for very dysfunctional families. Parental psychopathology has been found to be a predictor of outcome in the use of CBT for anxiety (Berman et al. 2000), depression (Brent et al. 1998 cited in Berman et al. 2000) and externalising disorders (Kazdin & Crowley, 1997 cited in Berman et al. 2000). If parents have mental health difficulties, or there appears to be significant family dysfunction then individual CBT is likely to be inappropriate and ineffective (Kaplan et al 1995 cited in Stallard 2002a). Thorough assessment should detect such issues and the need for systemic therapy rather than individualised CBT (Stallard, 2002a).

To summarise, it seems that CBT is appropriate for children if age appropriate material is used (Stallard, 2002a) and sufficient attention is paid to systemic and ethical issues (Berman et al. 2000, Doe et al. 2002). However, on a theoretical level, models of intervention developed through work with adults have mainly been applied to children (Stallard, 2002a). Research has identified similarities between adult and child maladaptive cognitive processing (Barrett et al. 1996). CBT can be made more appropriate through specifically designed models based on observations of children's cognitive processing and developmental issues (Stallard, 2002b).
The effectiveness of CBT with children

Effectiveness will be assessed in terms of statistically and clinically significant treatment effects, specific to the cognitive behavioural approach.

Why CBT is ineffective for children

It is impossible to conclude that CBT is effective in treating any child with a psychological disorder. CBT with children has not been clearly defined (Graham, 1998). CBT is an umbrella term for a number of different components delivered in a variety of combinations (Graham, 1998). Consequently researchers have examined different techniques in their studies. This, in combination with methodological flaws have made it difficult to generalise research findings. Treatment gains have not consistently been shown to be treatment specific (Durlak, Fuhrman & Lampman, 1991) and the medium and long-term benefits of CBT have not yet been established (Graham, 1998). These issues will be illustrated through a critical evaluation of the evidence base.

The best way of assessing the effectiveness of psychotherapy is through randomised controlled treatment trials (RCTs). However results of the few existing RCTs are ambiguous (Stallard, 2002b). For example, King et al. (1998) reported CBT was more effective in treating school refusal than a waiting list control. However, Last, Hensen & Franco (1998) reported CBT was no more effective in treating school phobia than a placebo control condition. The few published RCTs typically demonstrated the effectiveness of CBT over no intervention control conditions but have not always shown CBT to be more effective than other psychotherapies with children (Stallard 2002b).

Roth & Fonagy (1996) have questioned the generalisability of findings from RCTs. They have argued that in attempting to maximise the internal validity of research designs external validity is compromised. Roth & Fonagy (1996) have highlighted several differences between controlled research environments and clinical settings, three of which will be presented. Firstly, in clinical settings clients are not randomly
assigned to treatments, therapists negotiate with clients about the most appropriate intervention, this is usually influenced by presenting problems, client choices and availability of therapists and treatments. Secondly, whilst RCT participants are often diagnostically homogenous, co-morbidity of symptoms is the reality. Thirdly, whilst standardised, manualised treatments are adopted in RCTs, in practice clinicians vary in their level of skill in delivering interventions. Target & Fonagy (1996) argued that parents may be unwilling to consent to random allocation of conditions for their children. They also questioned whether it is ethical to put a child in a control condition, thus preventing them from having treatment (Target & Fonagy, 1996).

Due to the difficulties in conducting randomised controlled trials highlighted above, researchers have tended to carry out meta-analysis and systematic reviews instead. To establish that treatment gains are treatment specific, research needs to demonstrate that mood and behaviour have been modified through the identification and rectification of maladaptive cognitive processing (Stallard, 2002b). Many studies have relied on changes in diagnostic status or used behavioural measures to assess effectiveness of CBT without directly assessing changes in children's cognitions. (Stallard, 2002b).

Durlak and colleagues (1991) meta-analysis reviewed the relationship between cognitive and behavioural changes in sixty-four studies. They concluded behavioural changes did not result from cognitive changes. However, Stallard (2002b) argued that their rationale for this conclusion was vague. Research has examined the effectiveness of cognitive techniques and some examples of these are described later under the thought control technique section.

Durlak et al.'s (1991) meta-analysis found that on average, treated individuals were less symptomatic than 71% of individuals in the control group after treatment and at follow-up. Hence CBT has been shown to produce clinically significant change in childhood psychological difficulties. However, Shadish et al.'s (1993) meta-analysis of marital and family therapy found the average case treated with any form of family therapy were significantly more improved than 68% of untreated cases. In other words, both CBT and family therapy appear to be equally effective in treating children
with psychological difficulties and observed benefits in both studies may have been non-specific.

Some meta-analyses have considered the effectiveness of CBT in particular childhood psychological disorders. For example, Harrington, Whittaker, Shoebridge & Campbell’s (1998) systematic review concluded that CBT can be effective for young people with mild and moderate depressive disorder, but not for young people with severe depressive disorder. March (1995) concluded from a review that OCD in children could effectively be treated alone or in conjunction with medication. The long-term value of CBT in treating this client group is yet to be validated (Shafran, 1998). Bennett & Gibbons (2000) meta-analysis found CBT had a small to moderate effect on reducing levels of anti-social behaviour in children. Treatment effects were greater in older children. CBT has been shown to be most effective with children over nine years of age, although it can be used with younger children (Stallard, 2002a).

Other studies have shown CBT to be effective in treating anxiety (Kendall et al. 1997); PTSD (Smith, Perrin & Yule, 1999); chronic pain (Sanders, Shepherd, Cleghorn & Woolford, 1994); inter-personal problems (Spence, Donovan & Brechman-Touissant, 2000) and OCD (Benazon, Ager & Rosenberg, 2002). However, this research has methodological flaws. The last listed and most recent two studies will be critically evaluated.

Benazon and colleagues (2002) examined the efficacy of a twelve-week open trial of manualised CBT in the treatment of sixteen outpatients aged eight to seventeen diagnosed with OCD. Ten participants experienced a 50% drop in symptoms and seven were symptom free after treatment. The authors claim that these findings suggest CBT alone (without medication) can be used to treat OCD.

Benazon et al. (2002) highlight the weaknesses in their study, the main five are listed. Firstly, it had a very small sample and secondly it did not include a long-term follow-up. Thirdly, raters of symptoms were not blind. Fourthly, the treatment included cognitive training, exposure, response prevention and family interventions. It was not possible to identify the relative contributions of these elements. Fifthly, there was no
placebo, so it is unclear whether observed treatment effects were due to CBT alone. In addition to these acknowledged weaknesses, the following criticisms can be made. There was no control group, so the reader is unclear whether there was a significant difference between observed effect and rate of spontaneous remission. The impact of the treatment on the system was not addressed. Although the authors clearly described their inclusion and exclusion criteria they did not report how many were considered for treatment, found suitable and accepted it. Had this information been included, it would have given the reader an idea of how applicable the therapy is to a wide range of children.

Another recent study raised some interesting questions (Spence, Donovan & Brechman-Toussaint 2000). This investigated the effectiveness of CBT with and without parental involvement in fifty 7-14 year olds diagnosed with social phobia. Participants were randomly allocated to one of three conditions: CBT; CBT and parent involvement, or a waitlist control. Participants in treatment conditions were significantly less likely than those in the control condition, to have retained their diagnosis post treatment and at follow up. Whilst there was no statistical difference between treatment conditions, a greater proportion of children in the parent involvement condition were diagnosis free at the end of treatment (Spence et al. 2000).

Spence and colleagues (2000) acknowledged several weaknesses in their research. For example, the small sample size meant that conclusions made about impact of parental involvement at twelve month follow up need to be regarded as speculative. The homogenous sample employed for this study was not representative of the majority of children with social phobia who frequently have co-morbid symptoms (Last, Perrin & Hersen 1992, cited in Spence et al. 2000). In the absence of a placebo condition, it is unclear whether treatment effects are specific to the therapeutic approaches employed or whether they were non-specific, such as therapist attention or group participation.

In addition to these acknowledged weaknesses, the study failed to assess the effectiveness of parent training alone. The authors did not report parents' mental
health and whether or not children and parents were involved in concurrent psychotherapy. Parental mental health may have had an impact on how well parents were able to support their child in any of the three conditions (Berman et al. 2000).

This research raised the question of whether group or individual format is most effective for the delivery of CBT for children. Schneider (1992) found social skills training to be more effective when delivered on an individual rather than a group basis. Spence and colleagues (2000) argued that the CBT might have been overinclusive with too many therapeutic components; the various elements may have diluted the possible treatment effect of others.

**How CBT can be made more effective for children**

The effectiveness of CBT can only be established through the development of a clear definition of CBT for children (Stallard, 2002b). This can be achieved through examining the effectiveness of the wide range of techniques which fall under the umbrella term CBT (Stallard, 2002b). Further research is needed to establish which techniques are effective since current findings, some of which are described later, are ambiguous. There are no systematic analyses of the relative strengths of alternative combinations of these components (Stallard, 2002b). Future research should also consider how these components should be sequenced and combined to make up the most effective treatment package for children (Stallard, 2002a). CBT with younger children has often entailed mainly behavioural work with only a small cognitive element (Stallard 2002b). For example, the treatment for conduct disorders which, is, other than explaining the rationale to parents, behavioural (Graham, 1998).

The most common components of CBT with children are: affective management, self-control; self-instructional training, graded exposure; psychoeducation; affective and thought monitoring; cognitive restructuring; behavioural experiments; reinforcement; role play and rehearsal (Stallard, 2002a). The effectiveness of four key components: affective management, self-control, self-instruction and graded exposure will be examined and suggestions will be made about how they can be made more effective for use with children.
Affective management

Reynolds & Coats (1986) found relaxation training significantly more effective than a waitlist control condition and as effective as self-control techniques in the treatment of moderately depressed adolescents. Furthermore, relaxation training reduced anxiety levels in these depressed individuals more successfully than self-control techniques and no treatment.

An effective way of helping young children to manage their feelings is by teaching them how to tense and relax their muscles through a game of Simon Says (Stallard, 2002a). Older children may be encouraged to describe their ideal relaxing place in depth, including sounds and smells (Stallard, 2002a). Metaphors such as the Angry Volcano can be effective in helping children with aggressive outbursts to remain feeling in control of their emotions (Stallard 2002a). Children can be helped to become more familiar with their thoughts and feelings by plotting factors that lead to outbursts in the shape of a volcano so that they are more able to recognise the build up to a potential outburst and intervene to prevent it (Stallard, 2002a).

Self-control techniques

Self-control techniques have been shown to be effective in treating aggression, impulsivity and hyperactive behaviour (Hinshaw & Erhardt, 1991). Grossman & Hughes (1992) found it was effective in treating internalising disorders, but less effective in treating children with somatic problems.

Reynolds & Coats (1986) reported that self-control techniques were successful in reducing depressive symptoms in adolescents. Reynolds & Coats acknowledged that the small sample size and the use of a single therapist across both treatment conditions are flaws in their design. The study can also be criticised for the short period between post treatment and follow up assessments. Participants were recruited from schools and were not formally diagnosed as having a major depression according to the DSM-III or Research Diagnostic criteria. It is therefore questionable how applicable these findings are for the treatment of children with severe and entrenched symptoms that
present at clinics. It can also be argued that the group format used here is not practical
in the clinic setting (Harrington, 1993).

An effective way for children to have control over their thoughts is to visualise a tape
recorder going round in their head with their thoughts playing on it (Stallard, 2002a). The child is encouraged to believe that s/he can stop the tape at any time (Stallard, 2002a). Younger children may find this difficult to understand and may benefit from
drawing their thoughts or writing them down and then putting the piece of paper in a
worry box, only to be opened with the therapist or parent (Stallard 2002a).

Self Instruction Training (SIT) and Positive Self-Talk
outcome studies found SIT to be minimally effective in treating behavioural problems
and anxiety disorders. SIT was successful in treating aggressive boys, combined with
modelling (Goodwin & Mahoney, 1975, cited in Herbert, 1998) and aggressive young
offenders (Snyder & White, 1979 cited in Herbert, 1998)

SIT can be used to help a child stop and think more effectively. For example, Bailey
(2000) talks about young children with conduct disorders saying to themselves;
"Stop! Think! What can I do?" to slow down automatic responses. Positive self-talk,
a form of self-reinforcement, such as "Well done I did not answer back" can improve
the likelihood that the child will act appropriately in the future (Stallard, 2002a).

Graded exposure
A randomised clinical trial by Kendall and colleagues (1997) showed exposure was a
key factor in the improvement of children with anxiety disorders. However, this
research only assessed the relative effects of cognitive therapy versus the combined
effect of cognitive and behavioural therapy, as part of a treatment package, it was not
a test of behavioural therapy alone. The treatment package, known as 'Coping Cat'
has produced positive outcomes post-treatment and at follow-up (Kendall & Southam-
cognitive element of the Coping Cat programme was necessary to accomplish and facilitate change during the enactive exposure but without exposure, meaningful change would not have occurred.

The Coping Cat programme includes a number of cognitive elements whose effectiveness is demonstrated in this study. It was however, unable to demonstrate the relative efficacy of these individual treatment components. It was interesting to note that when youngsters were asked about the helpfulness of FRIENDS for Children programme, originally based on Kendall’s (1990 cited in Kendall et al. 1997) Coping Cat program, children rated the cognitive skills as more helpful than adolescents. Adolescents rated graded exposure as the most helpful component of the programme (Barrett, Shortt, Fox & Wescombe, 2001).

The concept of a graded hierarchy can effectively be used with children if it is described as a “fear ladder” (Shafran, 1998). The most frightening situations are placed at the top of the ladder and the least frightening constitutes the bottom rung on the ladder. A "fear thermometer" (Young & Brown, 1996) can be used to identify how frightening each task is and therefore which rung it should be placed on. Modelling is also an effective way of helping a child to engage in exposure (Shafran 1998).

Further suggestions on how to make CBT more effective for children.

There are a number of other factors that influence the effectiveness of CBT with children. For example, the child may initially avoid verbal communication. This can be eased through the use of creative materials such as puppets, the clinician adopting a rhetorical approach or moving to a more informal setting. (Stallard 2002a). A child may find it difficult to talk about presenting problems. Stories and narrative techniques such as externalisation (White, 1989) may enhance CBT, making it more effective. For example, a child suffering with encopresis may find it easier to discuss this potentially embarrassing problem if it is seen as a problem separate from his identity. "Sneaky poo" can be seen as an entity that the child with the help of his parents needs to fight (White, 1989). Stories can also be used in modelling and to
normalise symptoms. Another factor influencing the effectiveness of CBT is children’s ambivalence; they may be unable to identify goals or changes that they would like to make. This can be overcome through the use of motivational interviewing (Stallard 2002a).

In summary, it is impossible to conclude that CBT is effective because CBT for children has not been defined and research studies have limited generalisability (Stallard, 2002b). Further research is needed to clarify which therapeutic techniques are effective with which age groups presenting with which psychological disorders. Techniques that can be used to engage children in CBT and make it more effective include: puppets, drawings, metaphors, games, puzzles, visualisation, imagination and worksheets as long as they are pitched at an age appropriate level (Stallard, 2002a).

Conclusions

Theoretical, developmental systemic and ethical ideas have been used to argue that CBT is inappropriate for children. Suggestions about how CBT can be made more appropriate for this client group have been presented.

Firstly it has been argued that further research is needed into abnormal cognitive processing in children before it can be decided whether theoretical models developed for adults are appropriate for children (Stallard, 2002b). Secondly it has been argued that CBT is inappropriate because it requires abstract conceptual thinking that many children do not have. (Piacentini & Bergman, 2001). Finally, it has been argued that children should be seen as part of a system and therefore individual CBT is inappropriate.

CBT can be made more appropriate for children if developmentally appropriate theoretical models are designed to explain the development and maintenance of maladaptive processes in children (Stallard, 2002b). Abstract concepts need to be translated into simple, concrete understandable examples and metaphors to make CBT more appropriate for children (Stallard 2002a). Finally CBT can be made more appropriate by including teachers indirectly and parents directly in treatment (Stallard,
Ethical issues arise through including parents in CBT, such as who gives consent to treatment, who sets the goals of therapy (Doe et al. 2002). These can be overcome through fostering an environment in which such issues can openly be explored (Doe et al. 2002). Individual CBT alone is likely to be inappropriate for treating children from very dysfunctional families: it would probably be both more appropriate and more effective to conduct family therapy in this situation.

The lack of a clear definition of CBT for children and what it entails combined with the lack of research demonstrating treatment specific effects makes it impossible to conclude that CBT is effective for all children at any age and with any presenting difficulty. The few randomised controlled treatment trials in this area have produced ambiguous results (Stallard, 2002b), which have limited utility in clinical settings. Current research suggests it is more effective than no treatment but the medium and long-term benefits of CBT have not yet been established (Graham, 1998).

Current research suggests CBT is more effective in treating children over nine years of age (Stallard, 2002a) and it may be more effective when delivered in an individual rather than a group format (Schneider, 1992). Further research is needed on this.

It is helpful to consider the effectiveness of therapeutic components that when combined constitute CBT. This essay has focused on four common therapeutic components: affective management, self-control, self-instructional training and graded exposure. Suggestions have been made about how these therapeutic interventions can be made more effective for use with children. Further research on the effectiveness of individual components and the relative strengths of alternative combinations of these components is needed to establish a clear definition and treatment package of CBT for children (Stallard, 2002a).

It appears as though CBT has the potential to be both appropriate and effective with children. Individual characteristics of the child; presenting problem(s); family dynamics; age and stage of development are all factors which are likely to play a part in a clinician’s decision as to whether CBT will be appropriate and effective for their young client.
References


"Race and ethnicity are relatively unimportant variables in both the incidence and treatment of mental health difficulties in older people." Critically discuss this statement.
Introduction

The population is ageing and becoming more ethnically diverse (Ebrahim, 1996; Department of Health {DOH} 2001). This essay aims to critically explore the importance of 'race' and ethnicity as variables in the incidence and treatment of mental health difficulties in older people. It will be argued that incidence and treatment are linked because in order to provide Mental Health Services that are "accessible and appropriate" (DOH 2001 p.90) to all, accurate data on the prevalence and incidence of mental health difficulties of older people is crucial (Abramson, Trejo & Lai, 2002).

The concepts of 'race'; 'ethniciy'; 'incidence', 'treatment', 'mental health difficulties' and 'older people' will be described. Then research evidence on the differential incidence/ prevalence rates of mental health problems amongst older people will be critically discussed. Following this, research findings and salient issues on the differential treatment of older people will be presented and the importance of other identities will be highlighted. Implications and recommendations for appropriate practice, including the role of the clinical psychologist will be noted. Finally conclusions will be set out.

It must be highlighted that the author is a White British middle class woman drawing upon research predominantly conducted within the UK and USA. It is therefore possible that, despite trying to avoid this, the essay may have a slight Western bias.

Descriptions of key terms

The terms 'race' and ethnicity are concepts used to divide people into groups. 'Race' has focused on biological and physical differences between people (Patel et al. 2000). This has now been discredited since differences within 'racial' groups are greater than between 'racial' groups (Osbourne, 1971 cited in Fernando, 1991). For this reason, it will be written in inverted commas in this essay, as recommended by Patel et al. (2000). Ethnicity also refers in part to physical differences but is more flexible and can be seen as a group identity shared by individuals experiencing a similar socio-
political context (Fernando, 1991). Ethnicity has been defined as "a complex concept. It comprises skin colour, culture, language, religion, birth place, food, beliefs and behaviour." (Ebrahim, 1996 p.202). Whilst these terms differ, they have been used interchangeably (Cardemil & Battle, 2003) and thus will be considered as one variable in this essay, written as 'race'/ethnicity. This is demonstrated in the DOH (1998) definition of culture, another concept referred to in this essay: "culture encompasses the culture, artistic and intellectual accomplishments, religious beliefs and values of people who share the same racial or ethnic origin and/or language."(p.68). This quote demonstrates the tautological nature of definitions within this field that have been described as contentious (Dalai, 2002). The term 'ethnic minorities' will be used to refer to those who do not constitute the majority in the UK or the US (Cardemil & Battle, 2003).

The term 'incidence' has been defined by Moon & colleagues (2000) as "The number of new cases of a disease that come into being in a specified population in a specified time period." (p.38). This can be distinguished from 'prevalence': "the number of existing cases of disease or health condition in a specific population at some designated time or during some designated time period." (Moon et al. 2000 p.171). Incidence and prevalence are both concepts used to describe the rate of mental health difficulty (or physical difficulty) within a population. Incidence and prevalence studies on a given illness would use similar diagnostic measures (Silman, 1995). This essay aims to highlight concerns with such approaches to the rate of illness research.

Treatment will be considered at the individual, service planning and delivery level. With regard to 'mental health difficulties', depression, dementia (which are especially common in older people; DOH, 2001) psychosis and schizophrenia will be discussed. 'Older people' usually refers to those aged 65 and over (DOH, 2001) although at times has referred to the 55 and over (Barker, 1984 cited in Manthorpe & Hettiaratchy, 1993).
Incidence

The statement within the essay title is vague because it fails to suggest which variables may be relatively more important than 'race'/ethnicity in the incidence and treatment of mental health difficulties in older people. Numerous socio-demographic factors have been shown to influence incidence of mental health difficulties in older people, for example, "marital status, social class, educational background, degree of urbanisation and migration status" as well as 'race'/ethnicity (Nazroo & Sproston, 2002 p.12-14.). The first part of this essay will consider the importance of 'race'/ethnicity and will highlight the importance of other variables in the incidence of mental health difficulties in older people.

Research in this area is complex and riddled with methodological flaws (Adebimpe, 1994). UK research into the rate of mental health difficulties in older people has been limited and has focused more on prevalence than incidence. There has been more research on psychosis than 'common mental disorders' such as anxiety and depression (Weich & McManus, 2002).

Sproston & Nazroo, (2002) reported a large-scale community survey of ethnic minority psychiatric illness rates (the 'EMPIRIC' study). This study investigated rates of mental health difficulty in 16–74 year olds from Bangladeshi, Black Caribbean, Indian, Irish, Pakistani and the general White population living in private homes in Great Britain. Aside from this, studies have been on specific geographic locations (towns) and local ethnicities. A brief overview of disease rate research will be presented focusing on research from the UK.

Rates of depression, dementia and anxiety across ethnic groups

The NSF reported that 10-15% of people over 65 in Britain are depressed. Bhatnager & Frank (1997) investigated illness rates of elderly South Asian Immigrants (from India, Pakistan and Bangladesh) in a community sample in Bradford. They found 20% of their sample were experiencing depression, 4% dementia and 4% anxiety. Silveira & Ebrahim (1998) reported that 77% of Bengalis, 25% of Somalis and 25%
of Whites were depressed in London. In Liverpool, McCraken et al. (1997) found that in a community of ethnic minorities 2-9% were experiencing dementia and 5-19% were experiencing depression. Thus, with the exception of the Bengalis in Silveira & Ebrahim's (1998) research, only small ethnic group differences have been observed in the rates of depression and anxiety.

Rates of psychosis and schizophrenia across ethnic groups
Due to the infrequency of these conditions, research has tended to assess rates within the treatment setting rather than by population surveys (Nazroo & King 2002). Black Caribbeans have a three to five times higher rate of initial contact compared to the general population (Nazroo & King, 2002). Fabrega et al. (1994) reported that African–Americans were more likely to be diagnosed as psychotic than Anglo-European Americans. Inherent in this methodology is the assumption that all those with these difficulties will be in contact with services (Nazroo & King, 2002). The Epidemiological Catchment Area (ECA) survey (Robins & Reiger, 1991 cited in Adebimpe, 1994) in the US revealed greater 'racial' differences in the treated population compared to the general population. However contact with services reflects illness behaviour ("the way that symptoms are perceived, evaluated and acted upon") rather than illness itself (Nazroo & King, 2002 p. 53).

Illness behaviour is likely to be determined by factors associated with ethnicity such as health beliefs, expectations of the sick role and lay referral systems (Nazroo & King, 2002). These differences may be particularly pertinent to psychosis when individuals are being treated against their will (Nazroo & King, 2002). However, Marawha & Livingstone (2002) found older people were more likely to see schizophrenia as an illness and therefore seek help for it, than they were for depression and dementia that were often perceived as normal ageing. Schizophrenia may be overdiagnosed as a result of racism (Littlewood & Lipsedge, 1998 cited in Reelinghuys & Shah, 1997). Alternatively, schizophrenia may be prominent due to difficulties in diagnosing dementia and depression in older people from ethnic minority backgrounds (Shah, 1992 cited in Reelinghuys & Shah, 1997). Methods of diagnoses and diagnostic tools are not often valid for cross-cultural use (Hays, 1996).
It can be argued, that in both practice and research, the importance of 'race'/ethnicity has been underestimated since inappropriate and invalid tools are used in assessment.

'Race'/ethnicity factors that influence incidence

Assessment tools
Prevalence and incidence rates are established through "screening, referral and diagnosis" with the aid of assessment tools (Mills & Edwards, 2002 p.285). Standardised assessment tools are often invalid for cross-cultural use since they usually reflect the culture in which they were designed (Mills & Edwards, 2002). Assessment tools need to be written in appropriate language, have high specificity and sensitivity and have culturally relevant norms (Rait & Burns, 1998).

Jang, Small & Haley (2001) emphasised the need to consider culture-specific expressions of difficulties in addition to translation of measures. In investigating the structure and validity of the short version of the GDS (the Geriatric Depression Scale) (GDS-SF) in Korea and the USA, the authors found the structure of the tool to be non-comparable due to “fundamental differences in the way that persons from each culture interpret and respond to questions regarding depressive affect.” (Jang et al., 2001 p.36).

Screening tools for dementia
The MMSE (Mini Mental State Examination), frequently used to assess cognitive impairment, has been translated into a few languages (Rait & Burns, 1998). However, lower scores on the MMSE have been associated with lower levels of education (Espino & Lewis, 1998). Incidence of dementia assessed using the MMSE would therefore be higher in cultures that place less value on education (Espino & Lewis, 1998).

Culturally-relevant assessments of dementia should only ask about actual date when assessing orientation in time, since individuals may not know their date of birth because of life circumstances or cultural beliefs placing less emphasis on such information (McCraken et al., 1997). When assessing long-term memory, the political
leader at the time of emigration should be asked about, rather than the political leader of the dominant culture (McCraen et al., 1997). Few ethnically-specific tools have been designed for older people from ethnic minorities (Rait & Burns, 1998).

Clinician bias
Whaley (1997 cited in Mills & Edwards, 2002) argued that even when individuals present with the same symptoms, they are judged differently by clinicians, according to the client’s ‘race’/ethnic background. Clinicians are unable to recognise psychological distress in clients from a different ‘race’/ethnic background when it is expressed differently from the general population (Whaley 1997 cited in Mills & Edwards, 2002). The importance of 'race'/ethnicity have been overlooked by researchers who have used "inappropriate disease categories to assess illness experience which can lead to 'category fallacies'" (Kleinman, 1987 cited in Nazroo, Fenton, Karlson & O'Connor 2002 p.137). In other words, low rates of a particular difficulty within a certain culture may be because it does not exist or present itself in that way in that culture.

Apparently low rates of certain illness' within the South Asian group may be partly due to different symptomatic experiences and the existence of 'culture-bound syndromes' (Nazroo et al., 2002). For example, 'sinking heart', a mental health difficulty reported by Punjabi people has been frequently ignored by Western research (Nazroo et al., 2002). This highlights a weakness of the 'etic' approach that may fail to recognise culturally specific symptoms and "doesn't provide insight into cultural differences between groups." (Rait & Burns, 1998 p.271). However, the etic approach does enable cross-cultural comparisons which the alternative 'emic' approach does not (Rait & Burns, 1998). The emic approach uses tools developed within the culture which are therefore valid (Rait & Burns, 1998). Ideally, cross-cultural research should combine the strengths of both approaches (Rait & Burns 1998).
Differences in perceptions of mental health difficulties

Marwaha & Livingstone (2002) were the first to examine White British (WB) and Black African-Caribbean (AC) opinions on depression and what constitutes appropriate help for this problem. Forty participants were interviewed using two vignettes, one about an older man with depression, the other about an older woman with psychosis. Depression was considered a problem by all participants, however few of them saw it as an illness and therefore viewed medical help as inappropriate (Marwaha & Livingstone, 2002). A depressed individual was blamed for their difficulty in both ethnic groups; within the AC group, the depression was attributed to the individual lacking spiritual commitment (Marwaha & Livingstone, 2002). Psychosis, however, was considered by all to be an illness (Marwaha & Livingstone, 2002).

Marwaha & Livingstone (2002) claim that this research can be generalised to other older people of WB and AC origin living in inner cities within the UK but acknowledge their findings cannot be applied to other ethnic groups. They also acknowledge that if culturally specific symptoms had been considered in designing the vignettes, the results may have differed (Marwaha & Livingstone, 2002). In addition to their acknowledged weaknesses, it can be argued that gender may have influenced their findings. For example, had the character in the depression vignette been female, participants may have been more likely to see her as ill. Gender has been found to be an important variable in determining health care use (Husani et al., 2002).

Despite these limitations, the findings in this study have been supported by other research. For example, research by Alem, Jacobsson, Araya, Kebede & Kullgren, (1997 cited in Silveira & Allebeck, 2001) in Ethiopia using local psychiatrists. Whilst participants recognised psychotic symptoms as mental illness, subjective symptoms of depression were mostly unrecognised (Silveira & Allebeck, 2001). This implies that cultural beliefs are an important factor in determining rates of mental health difficulties in older people.
Other important variables in incidence

Gender combined with ethnicity seemed to be an important variable in the rate of common mental disorders (CMD) in the EMPIRIC study. "Compared with whites of the same gender, Irish men and Pakistani women had significantly higher and Bangladeshi had significantly lower rates of CMD." (Weich & McManus, 2002 p.34). It is interesting that gender was a more 'important' variable in determining rates of mental health difficulties in some ethnic groups compared to others. For those of White, Black Caribbean, Indian and Pakistani origin the risk ratio for females was about 1.5–2 whilst it was near unity in those with an Irish or Bangladeshi origin (Sproston & Nazroo, 2002).

This study could be used as a test of the 'multiple jeopardy' theory (Manthorpe & Hettiaratchy, 1993). This theory states that older women from ethnic minorities are particularly vulnerable to mental health difficulties because they experience ageism, racism, sexism and poverty, but may be protected if they have strong support systems (Manthorpe & Hettiaratchy, 1993). The Bangladeshi group may have been protected against mental health difficulties by their reported high levels of emotional and practical support (Stansfeld & Sproston, 2002). High levels of support could also explain why Somalis had similar rates of depression as Whites in London (Silveira & Ebrahim, 1998). Silveira & Ebrahim (1998) explain high levels of depression experienced by Bengalis by the multiple jeopardy theory. The authors also question the seemingly low levels of depression and anxiety in the Somalis, as this group were just as likely to be vulnerable to multiple or 'triple jeopardy' (for men) (Norman, 1985, cited in Manthorpe & Hettiaratchy, 1993). Silveira & Ebrahim (1998) claimed that Somalis under reported depressive symptoms due to religious beliefs and a lack of understanding.

Research by Ebrahim (1992 cited in Manthorpe & Hettiaratchy, 1993) indicates that socio-economic status is more important than 'race'/ethnicity in the rate of depression and anxiety. Wealthier Gujarati females in North London had lower levels of depression and anxiety than white women of the same older age group but lower socio-economic status (Ebrahim 1992, cited in Manthorpe & Hettiaratchy, 1993).
Age on migration may be a more important variable than actual 'race'/ethnicity in the incidence of mental health difficulties. 'Migrants' were found to have lower rates of mental health difficulties than 'non-migrants' (Nazroo & King, 2002). However this may be due to Western tools failing to detect alternative expression of psychological distress in those less integrated in Western culture (Nazroo & King, 2002).

Physical ill health has been associated with depression (Mills & Edwards, 2002). Older people from minority backgrounds are at higher risk of chronic disease than the indigenous population (Haley, Han & Henderson, 1998). Poor physical health has been related to SES (Appel, Harrell & Deng, 2002) so it is unclear whether older people from minority ethnic groups are more vulnerable to physical and, therefore, mental illness because of their 'race'/ethnicity or their SES.

Older people from ethnic minorities are likely to experience racism, a contributory factor to depression (Fernando, 1991). Cohort issues may also affect incidence rates (Haley et al., 1998). For example, older people that fought in war may have a higher incidence of mental health difficulties than a younger cohort from the same ethnic group, even when they reach old age (Haley et al., 1998). Many of the variables reported here, which are important in the incidence, are also important in the treatment of mental health difficulties in older people.
Treatment

'Race'/ethnicity differences in the treatment of older peoples' mental health difficulties

'Race'/ethnicity appears to affect the detection of psychological problems, the way in which they are diagnosed and the treatment that is offered (Llyod & Fuller, 2002). For example, although access to the GP may be satisfactory (Ebrahim, 1996), access to secondary care and social services seems to be more difficult for older people from ethnic minorities (Shah, 1998). Older people from ethnic minorities are less likely to be referred for psychotherapy than whites (Llyod & Fuller, 2002) and are more likely to be involuntarily hospitalised (Leo, Narayan, Sherry, Michalek & Pollock, 1997) and receive higher doses of anti-psychotic medication than whites (Chung, Mahler & Kakuma, 1995).

However, services may be more equitable if the importance of 'race'/ethnicity is recognised. Radelinghuys & Shah (1997) reported that 17% of clients in a geriatric psychiatry service in London were from an Indian subcontinent background, an ethnic group that forms only 7% of the local population. This service was accessible to those from the Indian subcontinent because the staff were bilingual and the service was based in close proximity to the Indian subcontinent community (Radelinghuys & Shah, 1997). This study highlights some of the barriers to mental health services which include language, a lack of appropriate health promotion and 'publication' of available services and beliefs about mental health problems and racism within mental health services (Mills & Edwards, 2002; Abramson et al., 2002).

Barriers to treatment

Language

Language is a barrier to services for some older people. Donaldson (1986, cited in PSIGE, 1994) found a third of participants were unable to read English and struggled to communicate using English. Information sheets should be translated into appropriate languages and written in accordance with the culture's health beliefs (DOH, 2001). National Health Service hospitals typically lack extensive interpreting
services and bilingual staff (PSIGE, 1994). Consequently, even if individuals do access services, an appropriate formulation and intervention is doubtful because of language barriers. Hays (1996) warned against using family members as interpreters for systemic reasons. PSIGE (1994) recommends advocacy for clients from minority ethnic groups.

Clinician bias and racism
Stereotypes of ethnic minorities are partly to blame for different treatment experiences (Abramson, et al., 2002). For example Asians "will look after their own" which is based on the assumption that extended families will look after older mentally ill people as 'they' live in multi-generational households (Ebrahim, 1996). Furthermore, surveys have shown that many older people from ethnic minorities live individually or just with a partner (Brahim et al., 1991 and Gillam, Jarman, White & Law, 1989 both cited in Ebrahim, 1996).

Difficulties arise when client and clinician perceive a problem differently (Abramson, et al., 2002). Clinicians need to be aware of cultural differences in the use of verbal and non-verbal communication (Abramson et al., 2002). Those from ethnic minorities may be less content than whites with consultations with mental health professionals (Jackson & George, 1998). However, this is a complex issue and it may be that the greater the discrepancy in educational background between 'doctor and patient' the less satisfactory the consultations for the patient (Jackson & George, 1998). Lower levels of education, like lower socio-economic status have been linked with certain minority groups who have had to cope with racism within the educational system (Jackson & George, 1998).

Other important variables in treatment
Religion
For many individuals, mental health difficulties are understood in spiritual terms (Haley et al., 1998) and thus help is sought from spiritual leaders (Bennett & Davis,
Clinicians should acknowledge and accept this in order to develop the most appropriate intervention with the best possible outcome (Bennett & Dennis, 2000).

Gender

Husani et al. (2002) found that women use outpatient services more than men across ethnic groups. Men, particularly African-American men, were most likely to avoid outpatients and rely on emergency services, which often led men to inpatient services (Husani et al. 2002). Women were more likely to use preventative care, seeking treatment before their difficulties became too serious (Husani et al., 2002). With regard to health care costs, Husani and colleagues (2002) reported there was no significant difference between the costs of inpatient care between African-American and White women, once age and psychiatric diagnosis was controlled for. African-American men had higher in-patient costs than White men but this may have been because assessment and treatment was mainly by white mental health professionals (Husani et al., 2002). The EMPIRIC study also found gender to be an important variable in the treatment of older people, with women consulting primary care services more than men (Llyod & Fuller, 2002).

Acculturation and cohort issues

It can be argued that degree of acculturation is more important than actual 'race'/ethnicity when thinking about treatment. Acculturation refers to the "process of maintaining an identity with one's own culture of origin while adapting to the dominant culture." (Gibson, Lokare & Tress, 2000 p.110). This process has been said to be harder for older people, without the possibility of integration through work or education (Haley et al., 1998). It may also be more difficult to acquire language for those with hearing difficulties (Haley et al., 1998). Lower levels of acculturation have been associated with higher rates of depressive symptoms (Lam, Pacala & Smith, 1997 cited in Haley et al., 1998) and less use of mental health services (Hernandez, 1992 cited in Haley et al., 1998).
Life events associated with particular cohorts may influence a cohort member's mental health status and help-seeking behaviours (Haley et al., 1998). For example, many of the current older people from ethnic minority groups in the UK immigrated to with the view to return to their home country once they had earned enough money may be depressed if they cannot afford to due to employment discrimination (Gibson, Lokare & Tress, 2000). Future generations within the same ethnic group may experience retirement differently. For example, being born in the UK and taking on a British identity may lead to different dreams for retirement and, hopefully, more financial security if institutional racism is overcome.

Psychotherapy

There has been limited research into ethnic differences in treatment preferences for psychotherapeutic approaches. This may be partly due to fear of creating stereotypes and generalising. The author of the essay is acutely aware of this herself and the importance of seeing each person as an individual. Nonetheless, in the same way that it is helpful to be aware of a client's cultural background, it is also useful to be aware of research on treatment preferences. A few examples will therefore be cited. Arean & Miranda (1996) have shown that Cognitive Behaviour Therapy (CBT) is a successful approach to use with depressed older adults from ethnic minorities. CBT may be more appropriate for Latinos/Hispanics than insight-oriented psychotherapy as it is more 'practical' and may be more empowering and less stigmatising (Davison & Neale, 1998). Conversely Native Americans may prefer a clinician who focuses more on listening (Paniagua, 1994 cited in Abramson et al., 2002). Interventions, which incorporate spiritual issues, have been found to be helpful for Hispanics and African-Americans (Abramson et al., 2002).

Implications and recommendations

Hays (1996) has acknowledged that there are many important variables in the assessment and treatment of mental health difficulties. Hays (1996) proposed the 'ADDRESS' acronym framework as a culturally responsive approach to assessment.
This encourages clinicians to consider "Age and general influence; disability; religion; ethnicity; social status and sexual orientation." (p.188). Hays (1996) stressed the importance of acknowledging all elements of an individual's identity and the fact that ethnic groups are not homogenous.

Hays (1996) also stressed the need for clinicians to be aware of their own identities and how these may impact their perceptions of clients. Knowledge of the client's culture background can help to guide culturally relevant and sensitive formulations and interventions (Abramson et al. 2002). Hays (1996) wrote "psychologists' understanding of their clients depends on their awareness of their own biases and gaps in knowledge about minority cultures and commitment to learning more." (p.193).

The role of the clinical psychologist

Nadirshaw (2000) highlighted the role of clinical psychologists in making mental health services “accessible and appropriate” (DOH 2001 p.90) for all. The author reported that clinical psychologists are involved in determining referral criteria and the characteristics used to describe mental health difficulties. Nadirshaw (2000) claimed that “the value base of clinical psychology is not neutral and is arguably reflective of the values held in the dominant culture in Britain (Nadirishaw, 1999).” (p.223). Clinical psychologists have an important role in ensuring that appropriate assessment tools and interventions are used within their service (Hayley et al., 1998).

Policy and service planning

The Royal Commission Long-term Care report (1999) claimed government policy should prioritise developing culturally aware services. Service users should be included in service planning and managers should make links with local communities (Nadirshaw, 2000). Further epidemiological research is required to inform service planning at a local level (Silveira & Ebrahim, 1998). Marawaha & Livingstone (2002) identified stigma as a barrier for attending mental health services and suggested that the referrer (often the GP) should encourage service use by stressing the benefits of attending. Shah (1998) also recommended health promotion within the
Older People Essay

GP setting and requested further campaigns such as the ‘Defeat Depression Campaign’ by the Royal College of Psychiatrists. Silviera & Alleback (2001) suggested that older people from ethnic minorities have health advocates.

Nadirshaw (2000) highlights the importance of employment practice. Ideally clinicians should be from similar ethnic backgrounds as their clients and this needs to be reflected in recruitment policies (Nadirshaw, 2000). However, a clinician's understanding is more important than homogeneity in ethnicity between client and therapist (Hays, 1996). Nadirshaw (2000) highlighted the role of the British Psychological Society in training and supervision on issues of 'race'/ethnicity.

Models of service delivery

Bennett & Dennis (2000) have discussed the advantages and disadvantages of ethnicity-specific services. These services appear to be better at engaging clients but do not have more successful outcomes in the US (Flaskerau & Hu, 1994, cited in Bennett & Dennis, 2000). Pharoh & Redmond (1991, cited in Manthorpe & Hettiaratchy 1993) reported the success of an Asian Day centre run by Asian women in London. However, it would be difficult to develop individual services for each ethnic group (Bennett & Dennis, 2000).

Dutt & Ferns (1998 cited in Bennett & Dennis, 2000) suggested improving the cultural awareness of mainstream services as well as developing some ethnicity-specific services. Ethnicity-specific services in the UK are likely to be developed by voluntary services (Bennett & Dennis, 2000) and may be less able to compete for funding (Bennet & Dennis, 2000). There is a danger that if ethnicity-specific services exist mainstream services will be less focused on ensuring their service is “accessible and appropriate” (DOH 2001 p.90) to all, believing that certain ethnic groups are catered for by the voluntary sector. The Sainsbury Centre for Mental Health (2002) requests that the DOH set out performance targets for services to meet in becoming “accessible and appropriate” (DOH 2001 p.90) to all.
Conclusions

'Race'/ethnicity is an important variable in the incidence and treatment of older peoples' mental health difficulties. Ethnicity shapes beliefs about mental health that in turn affect contact with services (Marwaha & Livingstone, 2002) and thus incidence data (Nazroo & King, 2002). Incidence research is hampered by Western tools which fail to recognise mental health problems in people from ethnic minorities (Rait & Burns, 2002).

Socio-economic status (SES), also an important variable in the incidence of mental health difficulties, is related to 'race'/ethnicity as institutional racism has meant that ethnic minorities have typically occupied low SES (Manthorpe & Hettiaratchy, 1993). Gender is an important variable in incidence of mental health difficulties, although ethnicity affects the relationship between gender and the incidence of mental health (Sproston & Nazroo, 2002).

Barriers to treatment mean that older people from ethnic minority groups receive a poorer standard of care than the general population and incidence figures are inaccurate since they frequently relate to the number of treated individuals (Nazroo & King, 2002). A vicious circle may occur if incidence figures are then used for future service planning (Abramson et al, 2002). Without accurate incidence and treatment data, it is impossible to provide services that are “accessible and appropriate” (DOH 2001 p.90) to all.

The relative importance of 'race'/ethnicity may vary at the individual level. For some individuals, their 'race'/ethnic background will be extremely important to them; for others, gender or class may be a more important identity with which they align themselves. These factors have been found to be important variables in the incidence and treatment of mental health difficulties.

'Racial'/ethnic groups are not homogenous and terminology used to describe groups is problematic (Abramson et al. 2002). For example, referring to 'Asians' is nonsensical since there are at least twenty sub-groups within this category (Tsai & Catensen, 1996 cited in Abramson et al., 2002). Clinicians need to be aware of 'race'/ethnicity
differences and have an understanding of one's own 'race'/ethnicity and how that influences one's view of the world (Hays, 1996).
References


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Adult Mental Health Placement

Summary of Placement Experiences

And

Case Report Summary
Adult Mental Health Placement Summary

Supervisors: Dr Georgia Mitchell and Dr Kathy Kavanagh

Summary of Clinical Experience
This placement involved working in a Psychological Therapies Service which was located within a multidisciplinary team setting. Sixteen clients were seen who were aged between 24 and 61 years. Their presenting difficulties included: depression; bipolar disorder; possible brain injury; difficulties with anger; anxiety; needle phobia; social phobia; obsessive-compulsive disorder; panic disorder and agoraphobia; visual hallucinations and paranoid schizophrenia. The main model of intervention was Cognitive Behavioural. Methods of assessment included structured and semi-structured interviews and psychometric measures such as the Wechsler Adult Intelligence Scale (WAIS-III), the Behavioural Assessment of the Dysexecutive Syndrome (BADS), the Beck Depression Inventory (BDI-II), and the Beck Anxiety Inventory (BAI).

Research Skills Gained
A screening questionnaire for the Psychological Therapy Service was designed, constructed and piloted as a Service Related Research Project.

Presentations given and additional experiences
Two presentations were made during the placement. A presentation was given to the Psychology Service on the Service Related Research Project. Another presentation, about obsessive-compulsive disorder, which linked theory and clinical practice, was made at the Cognitive Behavioural Workshop, a multi disciplinary forum. An Away Day for the Community Mental Health Team was co-facilitated. Supervisors were observed carrying out initial assessments and CBT sessions. A day was spent shadowing a Social Worker and an Occupational Therapist and visits were made to the Day Care Unit, the Forensic Team and the Mother and Baby Team. A study day on Personality Disorders was attended.
Case report Summary

The Assessment and Cognitive Behavioural Treatment of a 54 Year Old Male Client Presenting with Obsessive Compulsive Disorder

Reason for referral

John was referred to the Psychological Therapies Service by a psychiatrist who thought that he could benefit from Cognitive Behaviour Therapy (CBT) for his Obsessive Compulsive Disorder (OCD). John was married, had children and had been working as an untrained Prison Officer.

Assessment

The assessment highlighted that John experienced the following symptoms of OCD: intrusive thoughts regarding fire, burglary, and illness; behavioural compulsions - repetitive actions such as turning his clothes round, taking them off and putting them back on again and repeating domestic chores if he felt he had "done it wrong". John reported that these ritualistic activities would typically be carried out three times or a multiple of three times until it "felt right".

Baseline data were collected using the Maudsley Obsessional Compulsive Inventory (MOCI, Hodgson & Rachman, 1977), the Beck Depression Inventory II (BDI-II, Beck, Steer & Brown, 1996) and the Beck Anxiety Inventory (BAI, Beck & Steer, 1987). These measures indicated a moderate level of depression, a mild level of anxiety and particular difficulties with "checking" and "doubting".

Formulation

Salkovskis, Forrester, Richards and Morrison's (1998) CBT model of OCD was used to develop an understanding of John's difficulties. This model emphasises the degree of perceived personal responsibility in those who experience OCD - that is the belief that one can bring about or prevent negative outcomes. John's childhood experiences that involved feelings of responsibility, together with his long history of anxiety, may have predisposed him to develop OCD. The relatively recent death of his mother was viewed as a contributory factor and the suicide attempts of prisoners that he witnessed...
were viewed as triggers to the OCD. John's compulsive behaviour and avoidance of situations linked to the obsessional thought were considered to be maintaining factors.

**Intervention**

John was seen for seven sessions of cognitive behavioural therapy. Some of the key elements of the intervention were: socialisation to the model; collaborative development of therapy goals; cognitive restructuring, verbal reattribution and behavioural experiments.

**Outcome**

Over the course of therapy, John managed to reduce his over inflated perception of responsibility of harm. At the beginning of therapy John completely believed (100%) that thinking something made it more likely to happen, by the end of therapy this has shifted a great deal, he claimed 2% of him still believed that thoughts could make things happen. Objective measures indicated marked reductions "checking", "doubting", anxiety and depressive symptoms: his score on the BAI indicated no anxiety and the BDI-II indicated John was now within the normal range.

**References**


Learning Disabilities Placement

Summary of Placement Experiences

And

Case Report Summary
Learning Disabilities Placement Summary

Supervisor: Allan Davis

Summary of Clinical Experience

This placement was in a Learning Disabilities Health Team (LDHT) setting located within a day unit for clients with challenging behaviour. The main model of intervention was behavioural and 11 clients, aged between seven and 62, were seen independently. An assertiveness group based at a warden-controlled residency was co-facilitated. Clients with mild, moderate and severe learning disabilities were seen and presenting issues included: transitional issues, engaging in self-injurious behaviour, demand creation behaviour and parenting problems. Indirect work was carried out with parents and staff teams. Methods of assessment included: observation; functional analyses; semi-structured interview and the following psychometric measures: the Vineland; the Dementia Questionnaire for People with Learning Disabilities; the British Picture Vocabulary Scale (BPVS) and the Wechsler Adult Intelligence Scale (Revised Edition) (WAIS-R).

Teaching and additional experiences

A teaching video was made with a Speech and Language Therapist, demonstrating how to manage challenging behaviour. Face-to-face teaching with staff and parents was also conducted. During the course of the placement a couple of presentations were attended, one on depression and another on personality disorders. Fortnightly multidisciplinary team meetings were attended. Team members such as the psychiatrist, Speech and Language Therapist and Nurses were shadowed. Local services such as residential homes and special needs schools were visited.
Case Report Summary
The Assessment and Behavioural Treatment of a 13 Year Old Female Client Presenting with Challenging Behaviour

Reason for referral
Sally was referred to the service by the Community Child Health Team for advice on how to handle her challenging behaviour that was presenting management difficulties for her parents and teachers at her special needs school. Sally had a severe learning disability, epilepsy, sight and hearing difficulties amongst other health problems. Sally had a history of challenging behaviour which her parents reported was becoming more difficult to manage through physical means as she grew larger and gained weight. Sally lived with her parents and older sister.

Assessment
The assessment comprised of indirect informant based interviews with Sally's parents, paediatrician and teachers and direct observations. Direct observations were carried out at home, school and out shopping with her family. Her parents also kept frequency and Antecedent Behaviour Consequence (ABC) records. A topography of behaviour was written, defining the target behaviours. Event recording and functional analysis was carried out to identify which behaviour occurred most frequently and the function of these behaviours. Since all identified challenging behaviours appeared to serve the same function, a simple intervention was designed for one behaviour (taking her clothes off in public) that could then be generalised to all other challenging behaviours.

Formulation
It was hypothesised that Sally's challenging behaviour was reinforced by attention, the function of her behaviour being demand creation. The target behaviours led to high levels of attention being focused on Sally and reinforcing the behaviour. Sally's challenging behaviours appeared to have the antecedent of attention not being present or a signal that it was not available e.g. family members leaving the room.
Intervention

It was decided that the intervention should be carried out at home as Sally's parents reported more difficulty with behaviour management than her teachers, and because the intervention took place during the school holidays. The intervention was based on Emerson's (1995) model, that increasing the reinforcement for other, appropriate behaviour, using the reinforcer maintaining the target behaviour, should reduce the challenging behaviour. Emerson (1995) claimed that increasing the reinforcement of other more appropriate behaviours in combination with decreasing the reinforcement for the target behaviour would lead to a decrease in the inappropriate behaviour and an increase in the appropriate behaviour. Guidelines to manage Sally's behaviour were created and given to her parents, along with an explanation of how they should be put into practice. It was recommended that Sally's parents observed Sally's behaviour every five minutes. If Sally was not engaging in the target behaviour she should be reinforced with attention. Sally's parents were advised not to provide any verbal or eye contact during an episode of target behaviour.

Outcome

Prior to the intervention Sally was observed to engage in 131 challenging behaviours, and take her clothes off inappropriately 16 times, within a space of a week. Following the intervention, event recording showed that Sally had stopped taking her clothes off inappropriately within four weeks. The behavioural guidelines were extended to other challenging behaviours that were then observed to reduce to zero (per week) after seven weeks. Sally's parents reported having more "quality time" with Sally as a result.

Reference

Children, Adolescents and Families Core Placement

Summary of Placement Experiences

And

Case Report Summary
Children, Adolescents and Families Core Placement Summary

Supervisors: Dr Catharine Pedroza and Ms Susan Ellis

Summary of Clinical Experience
This placement was based in a Child and Adolescent Mental Health Service and a Children's Centre for the under fives. Fifteen clients, male and female aged between three and 16 were seen. Interventions were carried out with groups, children individually; parents and children, and families. The main models used were systemic and psychodynamic. Presenting difficulties included: school refusal; self-harm; physical abuse; behavioural difficulties; toileting difficulties; autistic symptoms and language difficulties; anxiety and panic; parenting issues. Assessments involved semi-structured interviews and the use of the Wechsler Intelligence Scale for Children, Third Edition (WISC-III) and the Wechsler Preschool and Primary Scale of Intelligence (WPPSI).

Teaching, research and additional experience
A presentation on the use of cognitive behavioural therapy with children was made to Day Centre staff. Parents were advised on behavioural management. A proposal for the major research project was submitted to the Trust's Ethics and Research and Development Committees. A meeting with the Ethics Trust was attended to discuss the proposal.

Meetings were attended with psychotherapists, art therapists, systemic therapists, nurses and psychiatrists in which each professional explained their role within the team. Regular contact with education welfare officers, schools and social workers was maintained throughout the placement. Multi agency meetings with social workers, foster carers and teachers were facilitated.
Children, Adolescent and Families Core case report summary
The Assessment and Treatment of a five year old female client presenting with encopresis - a family therapy approach

Reason for referral
Georgina Green was referred to the Child & Adolescent Mental Health Service (CAMHS) by a Consultant Paediatrician, who reported that Georgina "did not want to do any bowel action". Georgina lived with her parents, her older brother and younger sister.

Assessment
The initial assessment comprised two sessions. The Trainee worked without a reflecting team and although the entire family were invited to the clinic, Georgina's brother never attended. Georgina's symptoms seemed to fit the DSM IV (American Psychiatric Association, 1994) diagnostic criteria for encopresis. The Greens reported that Georgina only opened her bowels once every three to four weeks and this usually took the form of soiling. As a result Georgina occasionally smelt of faeces. Mr Green appeared to be much more involved in Georgina's toileting than Mrs Green.

Formulation
The formulation was informed by Protinsky & Kersey's (1983) family model of encopresis and Carr's (1999) model. There appeared to be marital tension between Mr and Mrs Green and a stable coalition was observed between Georgina and her father. It seemed as though marital disharmony was being expressed through Georgina, in the form of her encopresis. Possible predisposing factors identified included a chaotic family environment and possible attachment difficulties with her mother. Starting school may have motivated Georgina and her family to seek help to overcome the problem. Possible maintaining factors identified included a stable coalition between Georgina and her father and a distance between Georgina and her mother; and inconsistent parenting. Georgina's apparent high cognitive functioning and appropriate parental expectations regarding toilet training were considered to be protective factors.
Intervention
The Greens reported many failed attempts at overcoming the encopresis using behavioural techniques. The Greens had four therapy sessions which were based on Protinsky & Kersey's (1983) model. A direct task was designed to restructure the family organisation; to disengage the enmeshed parent and to involve the disengaged parent (Protinsky & Kersey, 1983). The direct task was for Mrs Green to spend some quiet time alone with Georgina, to talk about her feelings. Mrs Green initially struggled with the direct task and she talked about Georgina's "poohey hands". A bio-behavioural formulation was presented to the family at this stage in an attempt to further engage Mrs Green and develop her empathy. Mrs Green responded well to this reformulation and started to spend more time alone with Georgina and also helped her daughter develop a routine of sitting on the toilet after breakfast each morning. Mr Green took a step back and was less involved in Georgina's toileting.

Outcome
By the end of the therapy sessions Georgina was opening her bowels in the toilet most days (23 times a month). This was markedly different from the time of assessment when she soiled herself once or twice a month and hardly ever defecated in the toilet. However, the underlying marital disharmony was not tackled.

References


Specialist Adolescent Placement

Summary of Placement Experiences

And

Case Report Summary
Specialist Adolescent Placement Summary

Supervisors: Dr Catharine Pedroza and Dr Gwyn Carter

Summary of Clinical Experience
This placement occurred with in an Adolescent Inpatient Service and a Child Adolescent Mental Health Service (CAMHS). Fifteen young people, male and female aged between 10 and 17 were seen. Interventions were carried out with individuals, families and a group. The main model used was psychodynamic, however, systemic and cognitive behavioural models were also used. Three clients were carried over from the core placement to provide the experience of longer-term work with these clients who presented with complex needs. The psychodynamic work often involved the use of play and art materials, within the community and inpatient setting. Working with this complex client group involved a great deal of liaison with other professionals, within the team and with outside agencies. Presenting difficulties included: Anorexia, school refusal, self-harm, conduct problems, anxiety, Autistic Spectrum Disorder, ADHD, psychoses, psychotic depression and family breakdown.

Research and additional experience
Data for the Major Research Project was collected during the placement. This involved interviewing school refusers from CAMHS services within the trust. In addition, school attenders were interviewed at a number of secondary schools within the area. A three-day workshop was attended on the use of the family assessment measure – to assess family competence, strengths and difficulties. A self-harm assessment was observed. A psychotherapy conference and training on clinical governance were also attended. Joint clinical work was carried out with the Trainee Psychotherapist and the Systems Therapist.
Specialist Adolescent Case Report Summary

Brief Psychotherapy with a Fifteen year old Female In-patient

Suffering from Anorexia Nervosa

Reason for referral and Background information

Jenny was an inpatient receiving treatment for anorexia nervosa; she also had social communication difficulties. Her family were Baptists, her parents lived together and Jenny had an older sister and younger brother.

Assessment

The assessment involved reviewing previous detailed assessments, and an assessment of Jenny to develop an understanding of her internal world via drawings and projective tests. Projective tests identified the following main defence mechanisms, anxiety, denial and displacement.

Formulation

Malan's (1979, 2001) two-triangle model in combination with Carr's (1999) model was used to develop an understanding of Jenny's difficulties. A family history of mental health difficulties may have predisposed Jenny to develop anorexia and her transition to adolescence may have precipitated onset of anorexia. Possible maintaining factors identified included: Jenny's perfectionism, conflict avoidance and ambivalence within the family about fighting the anorexia.

There appeared to be a conflict for Jenny around the issue of independence versus dependence (Hidden Feeling). Jenny seemed to be anxious about asserting her independence as she feared this would lead to rejection from others, namely the Church, peers, Parents and the Therapist. The anorexia may have been a defence against this anxiety as it served the function of keeping her dependent and childlike.

Intervention

Jenny had eight sessions of brief psychotherapy to help her begin to understand her internal world. The therapy aimed to check out the formulation and provide a containing space and a therapeutic relationship in which transference could develop,
enabling the exploration of the triangle of conflict. Given Jenny's social communication difficulties and her ability to use art materials in the assessment, it was decided that art materials should be used in the therapy.

During the course of therapy Jenny began to share elements of her true self with the therapist through her pictures. Jenny was able to reflect on her abstract images and explain how she was feeling when she drew them. After a couple of sessions, Jenny demonstrated resistance that was viewed as an attempt to exercise her independence. Jenny was able to reflect on her resistance and the experience of not having been rejected for it.

Outcome

Jenny was able to explore how it felt to be different and disagree with others in the therapy. At the end of therapy she was describing feelings of anger with her parents, something that she was unable to do at the assessment. Jenny reported verbally, and through her pictures, that she felt much better than she had done on admission and this was reflected in her general appearance. Jenny had managed to gain a significant amount of weight and had started to take an interest in personal hygiene, clothes and make-up. Given that Jenny received an intensive treatment package, it was difficult to know the impact of her individual therapy on her improved sense of well-being. A comprehensive report was written as part of a referral for further individual work on an outpatient basis when Jenny was discharged from the hospital.

References


Older People Placement

Summary of Placement Experiences

And

Case Report Summary
Older People Placement

Older People Core Placement Summary

Supervisor: Ron Bracey

Summary of Clinical Experience
This placement involved working in a Community Mental Health Team for Older People and some in-patient work on the Older People psychiatric unit. Behavioural, Cognitive-Behavioural and Neuropsychological models were the main models adopted in client work. Clinical work was undertaken with 15 clients aged between 65 and 87. Independent work was undertaken with 8 women and 7 men. Joint work with the supervisor was undertaken with 1 male client. Presenting problems included: depression, Alzheimer's, memory loss, confusion, OCD, GAD, Agoraphobia, Health anxiety, relationship and sexual health. Difficulties. The following psychometric tests were used: the Wechsler Adult Intelligence and Memory Scales – third edition (WAIS-III & WMS-III); Wechsler Test of Adult Reading (WTAR); Repeatable Battery for the Assessment of Neurological Status (RBANS); Controlled Oral Word Association (COWA); Trail Making Test (TMT); Wisconsin Card Sorting Test (WCST); Hospital Anxiety and Depression Scale (HADS) and the Geriatric Depression Scale (GDS).

Additional experience
A presentation on the use of the RBANS was made to the multi-disciplinary team who were thinking of using this measure in their memory clinic. Clinical consultation was given to Community Psychiatric Nurses. Observations were made of a Clinical Psychologist's and a Psychiatrist's clinical work. Psychology, Stroke Team and Multi-disciplinary Team meetings were attended. A workshop on palliative care was also attended.
Older People Case Report Summary
A Neuropsychological Assessment of An 84-year-old woman with memory difficulties.

Referral
Susan was referred to Clinical Psychology by a Consultant Psychogeriatrician for an assessment of her memory difficulties and for a clarification of a diagnosis of Dementia of the Alzheimer’s Type (DAT).

Initial Assessment
Susan described a fourteen-year history of memory difficulties such as forgetting names and places and having numeracy difficulties, for example, not being able to calculate change in a shop. Susan said that she had experienced an episode of depression that was triggered by bereavement when she was in her early forties. Susan had never married or had children, she lived alone but spent most evenings with her neighbour. Susan recalled that an aunt (deceased at the time of assessment) had been diagnosed with Alzheimer’s. Susan had performed well at school and throughout her career as a social worker and group analyst.

Action Plan
It was hypothesised that Susan may be suffering from depression ('dementia syndrome of depression' Green, 2000) or DAT. Susan's neighbour was interviewed. A battery of neuropsychological tests was administered to establish a neuropsychological profile and develop an understanding of Susan's difficulties. The tests selected were:

- Wechsler Test of Adult Reading (WTAR, Wechsler, 2001)
- Repeatable Battery for the Assessment of Neurological Status (RBANS, Randolf, 1998).
• Trail Making Test (TMT, Reitan & Wolfson, 1995)
• Wisconsin Card Sorting Test (WCST, Heaton, 1981)
• Hospital Anxiety and Depression Scale (HADS, Zigmond & Smith, 1993).
• Geriatric Depression Scale (GDS, Brink, Yesavage, Lum Heersema, Adey & Rose, 1982).

Outcome
Although results suggested that Susan's general cognitive functioning was in the superior range, there was evidence of impaired memory, attention and executive function and reduced semantic fluency. Susan did appear to have mild to moderate depression according to the HADS and GDS. However Susan was motivated throughout the assessment process and it did not seem as though low mood was interfering with her performance. Furthermore Susan reported that while she has a tendency to feel low when she stopped and thought about things, low mood did not interfere with her daily living.

Conclusions and Recommendations
Conclusions were not definitive, test data and clinical presentation appeared to support the diagnosis of the early stages of DAT (Blass & Poirier, 1996, Green 2000). A feedback report was written for Susan and this was explained and discussed with her. Susan was given some strategies to help her manage her memory difficulties. A report was written for the Psychogeriatrician. Both reports recommended re-testing in twelve months to further clarify a diagnosis and help with care planning.

References


Please see Volume 2 of this portfolio for test references.
Specialist Addictions Placement

Summary of Placement Experiences
Specialist Addictions Placement Summary

Supervisors: Dr Shamil Wanigaratne and Dr Jenny Corless

Summary of Clinical Experience

This placement was based in three separate teams, an inpatient service and two community drug and alcohol services based in different locations. At least 30 clients were seen on this placement, some were on an individual basis, others were seen in a group. The main model adopted was Cognitive-Behavioural. A new in-patient group called "Thinking Choices" was co-designed and co-facilitated. Presenting difficulties included the following addictions: heroin; crack; cocaine; benzodiazepine; cannabis; poly-drug and alcohol. Clients experienced: anxiety; depression; schizophrenia; anger, trauma and bereavement Issues. Assessment measures used included: the Beck Anxiety and Depression Inventories (BAI and BDI-II), the Brief Symptom Inventory (BSI) and Young's Schema Questionnaire.

Additional Experience

An inpatient staff supervision group was attended. Regular community team staff supervision groups, run by the supervisor, were attended and the process of these groups was reflected on in individual supervision. Cognitive Behaviour Therapy workshops, a ward round, an allocation meeting, Psychology and Multi-disciplinary Team meetings were attended. Other addictions services, such as the Drug Testing and Treatment Order service and the Methadone Dispensing service were visited. Discussions about their role within the team took place with Consultant Psychiatrists, Drug Workers and Youth Workers.
Research Dossier
The Design, Construction and Pilot of a Screening Questionnaire to be used in Psychological Therapy Services.

Service Related Research Project

Year 1
June 2002
Acknowledgements

I would like to thank my field supervisor and other members of the service described in this report for their support, encouragement and help collecting data.

I would also like to thank my university supervisor and research tutor for their guidance and support through each stage of the project.

Abstract

Background

The NHS Executive document (2000) ‘Psychological Therapies Services, Working in Partnership’ argued the need to reduce waiting times as much as possible within given resources and to minimise multiple assessments and false starts.

Method

This project involved the development of a questionnaire and a quantitative and qualitative pilot study. It was exploratory and involved interviewing colleagues, designing a screening tool (questionnaire) and piloting the questionnaire.

Results

There was a good response rate to the questionnaire. Clinical Psychologists judged it to reduce non-attendance, waiting times and improve efficient management of the waiting list. However they thought that clients should not be screened out of the service solely on the basis of the questionnaire.

Conclusion

Whilst the psychologists consulted thought it should not be used as a screening tool per se, they thought that with amendments, the questionnaire should be used throughout the borough as an aid to assessment.
Introduction

Murray and Walker (1996) have suggested that client confidence in psychology service reduces and morale amongst clinical psychologists drops, as the waiting list grows. Non-attendance costs health services in terms of inefficiency and waste of clinicians' time.

Non-attendance

Client non-attendance at psychology outpatient service appointments has been estimated at between 10 and 50 percent (Henry, Ball and Williams, 1998) with several studies suggesting that the average is somewhere in the middle of this range (Shalan and Palmer, 1998). Non-attendance (DNA) is not always well defined in studies, but broadly refers to non-attendances for initial assessment and/or treatment dropout. Studies that have tried to tackle this problem have varied in their approach. Some have looked at client variables, such as unemployment and socio-economic status (Trepka, 1986). Others have looked at more psychological reasons for non-attendance such as motivation (Hughes, 1995). A consultancy model, whereby clinical psychologists assist other professionals to solve problems and plan interventions, has been documented as an approach to reducing non-attendance (Shalan and Palmer, 1998). More research has focused on strategies to encourage attendance such as pre-assessment information leaflets sent to potential clients (Webster, 1992), time-limited therapies (Sledge, Moras, Hartley, and Levine, 1990) and pre-appointment questionnaires (Henry, Ball and Williams, 1998).

National standards for waiting times

The National Service Framework for Mental Health (Department of Health, 1999), highlighted the need for a better assessment procedure in mental health services. Standards for maximum waiting times were six weeks for assessment and six months for therapy. The NHS Executive document (2000) 'Psychological Therapies, Working in Partnership', set up guidelines on how these standards could be achieved by Psychological Therapy Services. This argued the need to reduce waiting times as...
much as possible within given resources and to minimise multiple assessments and false starts.

**Pre-assessment questionnaires**

Mann (1986) reported three main functions of questionnaires used in general psychiatry: to identify psychiatric cases; to measure the severity of psychiatric symptoms and to standardise interviews to improve accuracy of assessment and diagnosis. Most instruments have one primary explicit function (Mann, 1986). Instruments are scrutinised for their reliability and validity (Mann, 1986). In contrast, questionnaires developed by Laing, Phillipson & Lee (1966) and Eysenck (1959) for use in psychotherapy, illuminate general differences between people, or indicate individuals' agendas for therapy (Mace, 1995). After the Second World War, which generated an influx of referrals, the London Clinic of Psycho-Analysis introduced a pre-assessment questionnaire as part of a screening process (Mace, 1995). The questionnaire asked prospective clients how they viewed their problems, general circumstances and previous psychiatric treatments. Since then, these psychotherapy pre-assessment tools have been adopted by other institutions, including NHS clinics.

Mace (1995) highlighted three primary functions of psychotherapy pre-assessment questionnaires: to provide information, to prepare the client and to boost attendance rates for assessments. In essence it reflects the psychoanalytic process rather than the medical model (Soutter and Garelick 1999). The client provides information about themselves and the psychotherapist attempts to understand it.

Pre-assessment questionnaires can give the clinician information supplementary to the referral letter. Jenkins (1993) found errors and omissions of between 5% and 28% in referral letters from general practitioners to outpatient departments. Referral letters of inappropriate clients were more than nine times as likely to omit the reasons for the referral compared with the referral letters of appropriate clients (Jenkins 1993).
Soutter and Garelick (1999) report that using questionnaires improves efficiency by reducing non-attendance. Clients that were not given a pre-assessment questionnaire had proportionately more assessment sessions than those given a questionnaire. They reported that if only the clients that completed questionnaires were seen, nineteen percent more assessment sessions would be freed up for an equivalent uptake in therapy.

It is difficult to measure the construct validity of this type of questionnaire (Soutter and Garelick 1999). Assessing clients is a subjective process and there are considerable difficulties in obtaining objective data with this type of questionnaire (Soutter and Garelick 1999). However, one can ask whether the questionnaire is helpful as defined by the following operational criteria: does it add to the efficiency of the assessment process as judged by experts?

Rationale for the study

The Psychology Service wanted to reduce non-attendance, improve management of the waiting list and to ultimately reduce waiting times to six weeks in accordance with the Department of Health (1999). At psychology meetings the Trainee Clinical Psychologist was encouraged to aid this process by designing a screening tool.

Aims

To improve efficient management of the waiting list. To achieve this by developing a screening tool to screen out inappropriate referrals so that an available resource could be matched to those best suited to benefit from the resource.
Method

Setting: The service comprised of a team of Psychologists taking referrals for psychological therapy from GPs, Psychiatrists and Primary Care counsellors. The team offered treatment to adults with mental health problems whom they believed might benefit from psychological therapy.

Design: This project involved the development of a questionnaire and a pilot study. It was exploratory and involved interviewing colleagues.

Participants: All seven clinical psychologists within Psychological Therapies Services were initially interviewed to gather data for the design of the screening tool. The questionnaire was then piloted on 40 clients at the top of the waiting list. Finally, two clinical psychologists who used the questionnaire were interviewed about its usefulness.

Procedures:

(1) Expert sampling was used to gather data regarding the content of the screening tool. The experts were Clinical Psychologists within the department. Interviews were semi-structured and the questions can be found in Appendix 2.

Psychologists were interviewed individually. There appeared to be a consensus although responses were not identical. The results were discussed with the project supervisors. Some suggestions were not included for reasons of space and lack of consensus amongst the psychologists. The tables below show the final set of topics included in the questionnaire.
### Table 1:
Criteria that the psychologists believed would make a prospective client inappropriate for the service.

<table>
<thead>
<tr>
<th>Factor Number</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>If the problem was too mild or too severe (assessed by how functioning was affected).</td>
</tr>
<tr>
<td>2</td>
<td>If they were more appropriate for another service.</td>
</tr>
<tr>
<td>3</td>
<td>If they were currently in ongoing therapy and/or if they had had several failed attempts at therapy in the past.</td>
</tr>
<tr>
<td>4</td>
<td>If they do not want to be seen by a clinical psychologist or if they were not ready to engage in therapy.</td>
</tr>
<tr>
<td>5</td>
<td>If distress was solely related to drug or alcohol issues.</td>
</tr>
<tr>
<td>6</td>
<td>If the person had a learning disability.</td>
</tr>
</tbody>
</table>

### Table 2:
Other information the psychologists thought could be collected by the screening tool.

<table>
<thead>
<tr>
<th>Factor Number</th>
<th>Factor</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Risk Assessment</td>
<td>Was the client at risk? Would the therapist have been at risk seeing the client alone?</td>
</tr>
<tr>
<td>8</td>
<td>Practical Issues</td>
<td>Did the client need wheel chair access? Would the client have difficulty attending an appointment between 9am and 5pm? If so, why?</td>
</tr>
<tr>
<td>9</td>
<td>General Final Question</td>
<td>Did the client have any further comment they would like to make?</td>
</tr>
</tbody>
</table>

The questionnaire designed is in Appendix 3.
Over a fortnight the questionnaire was sent to 40 clients on the waiting list. Demographic details of the participants are reported in the results section. Of these 40, 20 had already been sent an assessment appointment date, the other 20 had not. Two versions of a covering letter were written, one version for the former group the (see Appendix 4A) second for the latter group (see Appendix 4B).

Item analysis was carried out on the returned questionnaires to identify which questions were frequently answered appropriately and which seemed problematic for respondents.

Questionnaires were compared with referral letters. This was to assess whether the returned questionnaire gave the psychologist additional information.

The questionnaires were read by two clinical psychologists before the assessment appointments of 20 participants. After these appointments, the psychologists were interviewed to ascertain the content validity of the questionnaire and how useful they found the screening tool.

**Main outcome measure:** Qualitative data obtained through interviews with two clinical psychologists. Item analysis was carried out on the questionnaire data.

**Ethical considerations:** A covering letter to clients addressed issues of informed consent and confidentiality. See appendix 1 for a letter from the Medical Director confirming that this project did not need to go to the ethics committee.

**Results**

32 of the 40 questionnaires were returned. The demographics of these forty are shown in table 3 on the next page. Those that did not return the questionnaire (‘non-returners’) appeared to be slightly younger and more likely to have a diagnosis of
mood disorder than those that did return the questionnaire. Unfortunately the cultural background of ‘non-returners’ is missing data. See Appendix 6 for the categorisation of diagnoses.

Table 3
Shows the demographics of clients sent the questionnaire divided into two groups: ‘returners’ and ‘non-returners’.

<table>
<thead>
<tr>
<th></th>
<th>Returners</th>
<th>Non returners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Age</strong> (and standard deviation)</td>
<td>42 years (SD = 12)</td>
<td>35 years (SD=10)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of females in the group</td>
<td>20 (63%)</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>Percentage of males in the group</td>
<td>12 (37%)</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>Culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of white people in the group</td>
<td>27 (84%)</td>
<td>Missing data</td>
</tr>
<tr>
<td>Percentage of Indian in the group</td>
<td>3 (8%)</td>
<td>Missing data</td>
</tr>
<tr>
<td>Percentage of ‘Asian other’ in the group</td>
<td>1 (4%)</td>
<td>Missing data</td>
</tr>
<tr>
<td>Percentage of Irish in the group</td>
<td>1 (4%)</td>
<td>Missing data</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>14 (42%)</td>
<td>3 (38%)</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>12 (38%)</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>3 (10%)</td>
<td>1 (12%)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>3 (10%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
Item Analysis

Table 2, in Appendix 5 shows the degree of response to each question. For each question between 69% and 100% of respondents gave a complete answer. The mean number of absent and incomplete responses per question was 2 and the mode was 0.

Questions 1 and 2 had the poorest response; only 69% of respondents completely answered question 1 and 81% completely answered question 2. Question 1 read: “In the box below, please briefly describe the nature of your difficulties as you see them, mentioning how long you have had them”. Question 2 was “In the box below, please write what you see as the main reason for your difficulties. How do you think things got to how they are now?” Twelve respondents (ten for question 1 and two for question 2) only answered one part of these long questions.

Question 12 was only answered completely by 88%, possibly because it asked about socially undesirable behaviour. It read: “Have you ever become so angry that you have hurt/damaged someone else or property? Please circle the most appropriate answer: Yes, No. If you feel able to give us any further information on this, please do in the box below.” Four respondents answered yes to the first part but did not give any further information.

Answers to question 3 sometimes conflicted with answers to question 1. For example a client said they could not go out at all in response to question 1, but rated themselves as having no difficulty in coping with everyday tasks in question 3.

Comparisons with referral letters

Referral letters to the Psychology Service varied tremendously with omissions observed in most. Some gave detailed histories, others were one or two sentences long, for example, simply requesting “CBT for this man who suffers with OCD”. Whilst most referral letters used a psychiatric diagnosis, far fewer clients described their problems in these ways (asked in question 1). Rather, clients described their
problems in terms of difficulties experienced. It was often unclear whose idea the referral was (question 8).

Referral letters did not describe the clients' understanding of what a psychologist does (question 9), nor whether the client thinks that the psychology service could help them (question 10). Referral letters did not say when the client could attend (question 14) or whether the client had any special needs (question 15).

**Clinical Psychologists' comments.**

Full questions and answers from these interviews are in Appendix 7. In summary, the psychologists thought the questionnaire (with amendments) should be used throughout the borough and it should be called the Pre-Assessment Questionnaire. Appendix 8 contains the amended version of the questionnaire.

**Content of the Questionnaire**

Both psychologists believed all the questions were relevant. They thought it could be understood by people from different cultural backgrounds and they did not think that it was racially or culturally biased.

However they made some recommendations. Both psychologists thought the long questions (1, 2, 7 and 8) should have been divided into more specific shorter questions. One psychologist said there should have been an extra question about goals/expectations of therapy. The other psychologist said question 10: "Do you think our service could help you?" should have included "in what way?" Both psychologists said the client's name and address and the team and team's phone number should be specified on the front page of the questionnaire.
Can the questionnaire discriminate between appropriate and inappropriate referrals?
Both psychologists thought a completed questionnaire gave them a fairly accurate impression of a client's difficulty and level of need. If a client did not return their questionnaire they would not get an appointment. However, they thought clients should not be screened out of the service solely on the basis of their questionnaire because clients may find it difficult to accurately convey their needs on paper. Whilst each client was offered an assessment appointment, those judged by their questionnaire to be inappropriate, were given brief assessments. Most interviews were completed in 1 session. In the past assessment appointments have often lasted 2 or 3 sessions.

Practical Benefits of using the questionnaire
Both psychologists said the questionnaires helped them decide which clients to discuss in supervision prior to assessment. They claimed questionnaires enabled them to plan assessments better, and avoid doing very complex assessments at end of the day.

Does the questionnaire reduce non-attendance and waiting times and improve the efficient management of the waiting list?
Both psychologists thought the questionnaire would do all of these things. Their explanations for these comments are explored in the discussion.

Additional Unforeseen Benefits
The psychologists also reported that the questionnaire socialised the client to the collaborative Cognitive Behavioural (CB) approach used in therapy. It helped the client to decide what they wanted from therapy before they arrived.
Discussion

There was a good return rate for this questionnaire: 32 out of 40 sent out were returned, possibly because returning the questionnaire affected future care. Content validity of the questionnaire was demonstrated by both psychologists reporting that all the questions were relevant. Both psychologists said impressions gained from a questionnaire converged with impressions gained from face-to-face assessment, suggesting convergent validity. A future study should look at the reliability of this questionnaire, unfortunately time limitations meant that it was not possible to do so for this project.

Two-part questions and a question about violence had the poorest response rate. Short specific questions replacing the two-part questions should increase the response rate. It is more difficult to increase the response rate in taboo subjects such as violence. Whilst clients did admit to these difficulties they seemed reluctant to give further information, possibly in case they were judged for 'immoral behaviour'. Perhaps these questions were too intrusive for a postal questionnaire. Response rate may improve if, "If you feel able to", a phrase in the question which was designed to acknowledge and reflect the sensitive nature of the question, is removed.

According to the psychologists, the questionnaire enhances the assessment process as it includes questions that can be missed in a face-to-face assessment. The psychologists reported few DNAs because clients were only offered convenient appointments based on responses to question 14, that asked which times would be difficult. Identifying and then addressing failed attempts at therapy was also considered a positive outcome that would probably reduce future DNA rates.

The psychologists thought a new faster throughput, due to a reduced number of assessment sessions per client would cut waiting times. The questionnaire would improve the management of the waiting list since complex clients would be seen by qualified staff rather than trainees. Both psychologists also reported that they had
given clients who appeared to be inappropriate for the service, shorter slots at the end of the day.

The psychologists claimed the questionnaire socialises the client to the Cognitive Behavioural approach used therapeutically (CBT) by the psychologists. Pre-assessment questionnaires may be important therapeutically, (Ambrose and Ormrod, 1996) for example, they provide the client with an opportunity to express concerns about confidentiality, seeing a psychologist and talking about feelings. These anxieties can then be addressed early on in the assessment meeting (Ambrose and Ormrod, 1996).

Pre-assessment questionnaires can however function as a barrier to Psychological Services (Soutter and Garelick, 1999). Although the psychologists did not think the questionnaire was racially or culturally biased, 2 out of the 8 people who did not return the questionnaire had Asian sounding names. This may reflect stigma attached to having therapy. Such stigma is demonstrated by the case of one Indian client in the study who did not want to be contacted at home, this man still managed to complete the questionnaire. This highlights a further benefit of the questionnaire. The questionnaire can be used to communicate wishes and reduce the likelihood of clients with specific concerns, such as not wishing to be telephoned, from dropping out of the service. Further research would be needed to see whether the questionnaire functions as a barrier to the service.

**Future Research Recommendations**

A future study could attempt to quantify the usefulness of the questionnaire by auditing the number of DNAs a month for the year before and the year after the implementation of this pre-assessment questionnaire. One could audit trends in the rate of inappropriate referrals by profession. Following on from this, a similar screening tool could be designed for referrers.
The development and piloting of the questionnaire has been fed back to the Psychology Service. Evidence of this can be found in Appendix 9.

Conclusion

The Department of Health (1999) set standards for maximum waiting times and in response to this the NHS Executive (2000) document argued the need to reduce waiting times as much as possible, aiming to minimise multiple assessments and false starts. The questionnaire was designed to enable the psychology service to do this. An original aim of the questionnaire was to reduce false starts by screening out inappropriate referrals and not offering them any face-to-face contact with a psychologist. Whilst referrals cannot be deemed inappropriate for the service solely on the basis of their returned questionnaire, the questionnaire has been judged to reduce multiple assessments and minimise the number of false starts into the therapy process. It will therefore be implemented throughout the borough as an aid to assessment.
References


NHS Executive (2000) *Psychological Therapies Working in Partnership*


## Appendix

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A letter confirming that this project did not need to go to the ethics committee.</td>
</tr>
<tr>
<td>2</td>
<td>Interview Schedule used to generate valid items for the questionnaire</td>
</tr>
<tr>
<td>3</td>
<td>The Questionnaire.</td>
</tr>
<tr>
<td>4A</td>
<td>Letter sent to Clients who had already been given an initial appointment date.</td>
</tr>
<tr>
<td>4B</td>
<td>Letter sent to clients that had not already been given an initial appointment date.</td>
</tr>
<tr>
<td>5</td>
<td>Results of the Item Analysis</td>
</tr>
<tr>
<td>6</td>
<td>Categorisation of Diagnoses</td>
</tr>
<tr>
<td>7</td>
<td>Questions and Answers from the final interview with the psychologists</td>
</tr>
<tr>
<td>8</td>
<td>The Amended Questionnaire</td>
</tr>
<tr>
<td>9</td>
<td>Evidence of feedback to the service</td>
</tr>
</tbody>
</table>
Wednesday 12th December 2001

Dear ,

I hope that you have not been given conflicting responses.

I have read your proposal and feel it probably does not need to go to the Ethics Committee for formal approval.

Yours sincerely

[Name]

Medical Director

cc:
APPENDIX 2:

Interview Schedule used to generate valid items for the questionnaire

Prompts used are in brackets

Do you think that it would be helpful to have a tool that you could use to screen out inappropriate referrals to psychological therapies services, pre-initial assessment? Why, Why not?

What factors would indicate that a client was an inappropriate referral? (E.g. do you think that there are personal characteristics or certain types of problem that may be inappropriate.)

How would you ask about these factors on a postal questionnaire? (Go through each factor and generate a question and ideas of response formats e.g.: open/closed, likert scales, multiple choice.)

Are there any factors (either present or absent) that would automatically exclude someone from an assessment

Of those factors that you have identified, which factor would you consider to be the most important? (If you could only have one piece of information, what would that be?)

Do you think that it would be helpful if the screening tool would distinguish clients best suited to clinical psychology from those best suited to psychotherapy?

In your opinion, how is an appropriate psychology referral different from a psychotherapy referral?
Do you have any ideas about how a questionnaire should be designed in order to discriminate between these two types of referrals? (E.g. have you any ideas about questions that should be asked in order to determine which service is most appropriate for a client?)

What other information would you want from this form? What would you use that information for? Why is that important? (E.g. To obtain details frequently omitted from the referral letter, such as......)

Do you think that it would be helpful to have an overall score generated by the questionnaire, with 'cut-off' scores indicating appropriateness or otherwise for assessment?
# APPENDIX 3:

## CLIENT INFORMATION QUESTIONNAIRE

**Psychological Therapies Service**

**ADDRESS**

---

**ALL INFORMATION GIVEN WILL BE TREATED AS CONFIDENTIAL.**

- Your completed questionnaire will be kept in your file and will only be seen by professionals involved in your care.

1. In the box below, please briefly describe the nature of your difficulties as you see them, mentioning how long you have had them.

   

2. In the box below, please write what you see as the main reason for your difficulties? How do you think things got to how they are now?

   

   *In the next question, please indicate how much your difficulties have had an impact on your life during the past week. In answering each question use the scale from 0 to 3, where 0 refers to 'not at all', 1 refers to 'a little', 2 refers to 'moderately' and 3 refers to 'severely'.*

3. In the past **week**, how much has the problem interfered with your:

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Severely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work:</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Family/social relationships</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Ability to cope with everyday tasks</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
4. Are there any other factors in your life that may be related to your problem? For example, life events such as: redundancy; bereavement; birth of a child; break up of a relationship, major illness. Please write your answer in the box below.


5. Are you currently seeing any other professionals? Please tick any other professional who is currently involved:

(Please state how frequently you see those you have ticked, on the appropriate dotted line.)

CPN □ ....................................................
Nurse therapist □ ....................................................
Psychiatrist □ ...................................................
Occupational therapist □ ...................................................
Social worker □ ....................................................
Counsellor □ ....................................................
Psychotherapist □ ....................................................

Please state any other (e.g. Therapy group) ..................................................

6. If you are currently in any ongoing therapy, please give details in the box below.


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7. Please give details, in the box below, of any other talking therapies undertaken in the past, for example, counselling, psychotherapy, family therapy, group therapy or Art therapy, (including approximate dates and where). Please state whether any of these therapies were helpful.

8. Did you request the referral to psychology? If not, do you know whose idea it was that you should be referred to psychology? Please state whose idea it was, if you know, in the box below.

For the following questions please circle the most appropriate answer.

9. How much understanding do you think you have about what a psychologist does? Please circle the most appropriate answer.

   None   A Little   Enough   A lot

10. Do you think our service could help you? Please circle the most appropriate answer.

   Yes   No   Not Sure

11. Do you see yourself as having drug or alcohol problems at this time? Please circle the most appropriate answer.

   Yes   No   Not Sure

If your answer to the above question is yes, please give details in the box below.
12. Have you ever become so angry that you have hurt/damaged someone else or property? Please circle the most appropriate answer.

Yes           No

If you feel able to give us any further information on this, please do in the box below.

13. Do you get angry easily? Please circle the most appropriate answer.

Yes           No           Not Sure

14. Could you see there being any difficulties in making a commitment to attending weekly sessions between 9am and 5pm if therapy was offered (e.g. practical ones such as childcare, or more individual problems, such as making time for yourself in a busy schedule). Please circle the most appropriate answer.

Yes           No           Not Sure

If the answer is Yes or Not Sure, please give details.

15. Please give details of any special needs, you may have e.g. wheelchair access.
16. Please write your name and address in the space provided below so that we can identify your questionnaire, which will be kept in your file. Your file will only be seen by professionals involved in your care.

[Blank space for name and address]

17. Please tick one of the following that best describes your ethnicity:

- Black Caribbean □
- Chinese □
- Black African □
- Asian Other □
- Black British □
- Bangladeshi □
- Black Other □
- Pakistani □
- Indian □
- White □

Any Other please specify: _________________________________________

18. Do you have any further comment that you would like to make? (Please feel free to write on the back of this sheet if you need more space).

[Blank space for further comment]

THANK YOU FOR COMPLETING THE QUESTIONNAIRE.

PLEASE MAKE SURE THAT YOU HAVE ANSWERED ALL THE QUESTIONS AND RETURN THE QUESTIONNAIRE TO THE ADDRESS ON THE FRONT PAGE.
Dear

You should by now have received an appointment for assessment for psychological therapy at Resource Centre. We enclose a questionnaire for you to complete, so that we can get an impression of your current difficulties and how they are affecting your life.

If you have time, please return the completed questionnaire to the Psychological Therapies Service in the enclosed stamped addressed envelope. Alternatively, please bring it along to your appointment with Dr...... Please complete the questionnaire to the best of your ability but if you have difficulty completing the questionnaire please bring it with you to your appointment anyway.

Please complete the questionnaire honestly and accurately. There are no ‘right’ and ‘wrong’ answers; we are simply interested in your ideas and opinions. All information given will be treated as confidential. Your completed form will be kept in your file and will only be seen by professionals involved in your care.

Thank you,

Yours sincerely,

Trainee Clinical Psychologist. Chartered Clinical Psychologist.
APPENDIX 4B
Letter sent to Clients who had NOT already been given an initial appointment date.

Psychological Therapies Service
ADDRESS

DATE SENT OUT

PRIVATE AND CONFIDENTIAL

IT IS VERY IMPORTANT THAT YOU READ THIS LETTER

Dear

You have been referred to our department for an assessment for psychological therapy and you may have been on the waiting list for some time. We enclose a questionnaire for you to complete, so that we can get an impression of your current difficulties and how they are affecting your life.

Please return the completed questionnaire to the Psychological Therapies Service in the enclosed stamped addressed envelope. We will send you an appointment soon after we receive the completed questionnaire.

It is important that you send back the questionnaire within a week of receiving it. If we do not receive your completed questionnaire within two weeks we will assume that you no longer wish to be seen by a clinical psychologist. Please complete the questionnaire to the best of your ability, but, if you have difficulty completing the questionnaire and you still wish to be seen, please contact our secretary on the above phone number.
Please complete the questionnaire honestly and accurately. There are no 'right' and 'wrong' answers; we are simply interested in your ideas and opinions. All information given will be treated as confidential. Your completed questionnaire will be kept in your file and will only be seen by professionals involved in your care.

Thank you,

Yours sincerely,

Trainee Clinical Psychologist. Chartered Clinical Psychologist.
APPENDIX 5:

Results of the item Analysis

Table 2: Showing the degree of response to each question in the 32 returned questionnaires.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Number of People who did not answer the question (those that left it blank and those that misunderstood the question)</th>
<th>Number of People that answered Part of the question.</th>
<th>Number of People that answered each part of the question.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10 (31%)</td>
<td>22 (69%)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1 (3%)</td>
<td>5 (16%)</td>
<td>26 (81%)</td>
</tr>
<tr>
<td>3</td>
<td>3 (9%)</td>
<td>29 (91%)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>2 (6%)</td>
<td>30 (94%)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>2 (6%)</td>
<td>30 (94%)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>3 (9%)</td>
<td>29 (91%)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>2 (6%)</td>
<td>30 (94%)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>32 (100%)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>32 (100%)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>2 (6%)</td>
<td>30 (94%)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>1 (3%)</td>
<td>31 (97%)</td>
<td></td>
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<td>12</td>
<td>4 (12%)</td>
<td>28 (88%)</td>
<td></td>
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<td>32 (100%)</td>
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<tr>
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<td>32 (100%)</td>
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</tr>
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<td></td>
<td>32 (100%)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>32 (100%)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>2 (6%)</td>
<td>30 (94%)</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 6:

#### Categorisation of diagnoses

<table>
<thead>
<tr>
<th>Category</th>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mood Disorder</strong></td>
<td>Depression, mania, bipolar affective disorder, emotional difficulties, bereavement.</td>
</tr>
<tr>
<td><strong>Anxiety Disorders</strong></td>
<td>Anxiety, generalised anxiety disorder, stress, panic attacks, phobias, obsessive compulsive disorder, psychosomatic pain, post-traumatic stress disorder.</td>
</tr>
<tr>
<td><strong>Psychosis</strong></td>
<td>Psychotic episode, schizophrenia</td>
</tr>
<tr>
<td><strong>Personality Disorder</strong></td>
<td>Borderline personality disorder. Borderline personality disorder with schizoid traits.</td>
</tr>
</tbody>
</table>
APPENDIX 7:

**Questions and Answers from the final interview with the psychologists**

1. **How many completed questionnaires have you received?**
   
   **Interviewee 1**: had received 19 completed questionnaires and she had done a face-to-face assessment of 13 of these people who had completed the questionnaire.
   
   **Interviewee 2**: had received 13 completed questionnaires and had interviewed 7 people.

   *(CONTENT VALIDITY)*

2. **Do you think that the questionnaire includes everything it should? Can you think of any other questions that you think should be added to the screening tool?**
   
   **Interviewee 1**: It would be helpful to add, after question 2, a question about goals/expectations of therapy or what they would like to change or achieve through psychological therapy.
   
   **Interviewee 2**: Add to question 10 which says, “Do you think our service could help you?” the question “in what way?”

3. **Do you think that the screening tool includes any questions that it should not?**
   
   **Interviewee 1** and **Interviewee 2** both said that all questions were relevant and should be included in the questionnaire.
4. Were there any questions that led to an ambiguous response?

I1 and I2 both said that questions which have more than one part to them (1,2,7 and 8) should be split up to ensure each part of the question is answered. This could be done by splitting the box into 3 sections:

| Type of therapy | Dates | Helpful: Y or N |

This might mean the boxes need to be larger.

(Box to Q 8 could be smaller).

5. Do you have any comments about:

A) The ordering of the questions?
B) The wording of the questions?

I1 and I2 said the client's name and address should be on the front sheet. On the Questionnaire specify the team and phone number.

6. Did you think that the questions could be understood by people from different cultural backgrounds, or were they somehow euro-centric/racially/culturally biased?

I1 and I2 thought that the questionnaire could be understood by people from different cultural backgrounds. They did not think that it was racially or culturally biased. Although 2 out of 8 people who did not return the questionnaire had Asian sounding names. This could be a literacy problem or it could be about the service rather than the questionnaire. People from other cultural backgrounds might not want to talk to a therapist who is probably white. They may also not want to write their difficulties down.

I1 and I2 suggested that this could be audited by asking service users about the pre-assessment questionnaire and the service, through the means of a consumer
satisfaction questionnaire (although this might require them to write about their difficulties).

I2 reported that one Indian client who did not want to be contacted at home because he did not want his family to know the extent of his difficulties, still managed to complete the questionnaire.

7. How useful was the questionnaire in helping you decide whether or not each client was appropriate for therapy? (Convergent predictability)
I1 and I2 both said that it was very useful. Completed questionnaires which indicated that the client was inappropriate were given brief assessments. Having the information on the questionnaire enabled I1 and I2 to do more focused assessments. I1 and I2 both thought that clients should all be seen even if very briefly in case they lied on the form (one person had done this). Only if in therapy already would they be ruled out, however they may still be seen.

I1 and I2 both queried the validity of question 3 as this often conflicted with response to question 1. I1 and I2 thought question 3 should remain in the questionnaire until the CORE is sent out with the pre-assessment questionnaire.

8. Did the completed questionnaire give you an accurate impression of the client’s difficulties, severity of difficulty and level of need?
I1 and I2 said yes the questionnaire is a good indicator of complexity.

I1 and I2 reported the following additional benefits:
It helps to plan assessments e.g. don’t do most complex assessments at end of the day.
It helps to identify who to discuss in supervision before meeting the client for assessment. This means that one does not have to think on one’s feet as much and it makes the psychologists’ job easier.
9 Did your impression of the client generated from the questionnaire correspond with the impression you gained from your face-to-face meeting with the client?
I1 and I2 both said yes

10 Were there any clients that you would have excluded from assessment, or only offered a brief assessment appointment to on the basis of their completed questionnaire? What is this number as a proportion of the number of completed questionnaires received?
I1 and I2 said that all offered an assessment appointment. One person lied on form, therefore there is a need to see everyone face to face. However most interviews were completed in 1 session. Often in the past without this tool assessment appointments have lasted 2 or 3 sessions.

11. Do you think that this screening tool (with amendments) should be implemented? Why/why not?
I1 and I2 said yes it should be used across borough (with minor amendments mentioned above).

12. Do you think that it would help:
a. Reduce the non-attendance rates
I1 and I2 said since it would lead to better assessments, due to additional information gained from the questionnaire (these questions have not always been asked in the assessment, either because a therapist does not have time or s/he forgets or s/he does not see it as important to ask at the time).

Both I1 and I2 claimed that question 14, which asks people if they would have difficulty attending between 9am and 5pm means that we should avoid offering inappropriate appointment times to people. This was working and I1 and I2 have been able fit clients in accordingly.
I1 and I2 said identifying failed attempts at therapy in the past enables this to be addressed and therefore reduce DNA rates.

b. Cut down on waiting times and
I1 and I2: said yes due to faster through put.
-Just take on those clients who want to come.
-There is less chance of treatment failure.
- It enables one to prioritise assessment and treatment to those most in need. Also one can send these people the crisis line phone number in case they need it.

c. Improve the efficient management of the waiting list?
I1 and I2: both said it may help prioritise people most in need as mentioned above and send them the crisis line number. It helps identify more complex clients before they arrive. These can be seen by qualified staff rather than trainees. Also these clients can be given longer slots. People who seem inappropriate on paper may be given shorter slots at the end of the day.

13. If you think that the questionnaire should be implemented, what do you think it should be called?
I1 and I2: ‘The pre-assessment questionnaire’.

14. Are there any further comments you would like to make? If so please use the space below.
I1 and I2 reported that the questionnaire socialises the client to the CBT model. It shows the client that it is a collaborative approach. It helps the client to think about what they want from therapy before they arrive. I1 and I2 reported that the questionnaire also helps with risk assessment. According to I1 and I2 it is particularly useful in complex cases, as mentioned above, since one can arrange supervision before meeting the client.
APPENDIX 8:

Amended Version of the Questionnaire

PRE-ASSESSMENT QUESTIONNAIRE

Psychological Therapies Service

ADDRESS

ALL INFORMATION GIVEN WILL BE TREATED AS CONFIDENTIAL.

- Your completed questionnaire will be kept in your file and will only be seen by professionals involved in your care.

1. Please write your name and address in the space provided below:

   Name (Miss/Mrs/Ms/Mr):

   Address:

   Post code: Contact telephone no.

2. In the box below, please briefly describe the nature of your difficulties as you see them. Please state how long you have had them.

   Current problems: How long for?

   In the next question, please indicate how much your difficulties have had an impact on your life during the past week.

   In answering each question use the scale from 0 to 3, where 0 refers to 'not at all', 1 refers to 'a little', 2 refers to 'moderately' and 3 refers to 'severely'.

3. In the past week, how much has the problem interfered with your:

   Not at all A little Moderately Severely

   Work: 0 1 2 3
   Family/social relationships: 0 1 2 3
   Ability to cope with everyday tasks: 0 1 2 3

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4. In the box below, please write what you see as the main reason for your difficulties? Please state how you think things got to how they are now?

5. Are there any other factors in your life that may be related to your problem? For example, life events such as: redundancy; bereavement; birth of a child; break up of a relationship, major illness. Please write your answer in the box below.

6. In the box below, please describe your expectations of therapy, if offered. What do you hope psychological therapy might help you achieve or change?

7. Did you request the referral to psychology? If not, do you know whose idea it was that you should be referred to psychology? Please state whose idea it was, if you know, in the box below.

For the following questions please circle the most appropriate answer:

8. How much understanding do you think you have about what a psychologist does? Please circle the most appropriate answer.

None A Little Enough A lot
9. Do you think our service could help you? Please circle the most appropriate answer:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Not Sure</th>
</tr>
</thead>
</table>

10. Please state, if you can, how you think our service could help you in the space below:

11. Are you currently seeing any other professionals? Please tick any other professional who is currently involved:

(Please state how frequently you see those you have ticked, on the appropriate dotted line.)

- CPN ......................................................
- Nurse therapist ........................................
- Psychiatrist .............................................
- Occupational therapist ............................
- Social worker ...........................................
- Counsellor .............................................
- Psychotherapist ......................................
- Please state any other (e.g. Therapy group) ..............................................................

12. If you are currently in any ongoing therapy, please give details in the box below, including who with, how long for and when this is due to end:

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13. Please give details, in the box below, of any other talking therapies undertaken in the past, for example, counselling, psychotherapy, family therapy, group therapy or Art therapy, (including approximate dates and where). Please state when therapy took place and whether any of these therapies were helpful.

<table>
<thead>
<tr>
<th>Previous Therapy:</th>
<th>When?</th>
<th>Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Yes/No)</td>
</tr>
</tbody>
</table>

14. Do you see yourself as having drug or alcohol problems at this time? Please circle the most appropriate answer.

Yes  No  Not Sure

If your answer to the above question is yes, please give details in the box below:

15. Have you ever become so angry that you have hurt/damaged someone else or property? Please circle the most appropriate answer.

Yes  No

If you feel able to give us any further information on this, please give details in the box below.

16. Do you get angry easily? Please circle the most appropriate answer.

Yes  No  Not Sure
17. Could you see there being any difficulties in making a regular commitment to attending weekly appointments between 9am and 5pm, if therapy was offered (e.g. practical difficulties such as childcare arrangements, or more individual problems, such as making time for yourself in a busy schedule). Please circle the most appropriate answer.

Yes  No  Not Sure

If the answer is Yes or Not Sure, please give details in the box below.

18. Please give details, in the box below, of any special needs, you may have e.g. wheelchair access.

19. Please tick one of the following that best describes your ethnicity:

- Black Caribbean
- Black African
- Black British
- Black Other
- Indian
- Chinese
- Asian Other
- Bangladeshi
- Pakistani
- White

Any Other please specify: ____________________________

20. Do you have any further comment that you would like to make?

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

Please make sure that you have answered all the questions and then return the questionnaire, as soon as possible, to the address at the top of the front page.

You will be sent an assessment appointment soon after we have received your completed questionnaire.
22 May 2002

Dear

Thank you for presenting your Service Related Research project at our Borough Psychology Research Forum on 20.02.02. Your detailed feedback regarding the development and piloting of your questionnaire was well received by all who attended.

The questionnaire resulting from your work on placement has already proved to be of great value to the Psychologists in ... and you have made an important contribution to the service.

Many thanks and best wishes,

Chartered Clinical Psychologist
Logbook of

Research Experiences

September 2001- September 2004-07-04

Years 1, 2, and 3.
**LOG OF RESEARCH EXPERIENCE**

<table>
<thead>
<tr>
<th>Research Skill/Experience</th>
<th>Description of how research skill/experience acquired</th>
<th>Date research skill/experience acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a literature search</td>
<td>• Literature searches were conducted for all four essays, five case reports, the Service Related Research Project (SRRP) and the Major Research Project (MRP). The literature searches were conducted using BIDS, OVID, Medline, Psych Info and other Internet Search Engines.</td>
<td>Year 1 (2001-2002) \ Year 2 (2002-2003) \ Year 3 (2003-2004)</td>
</tr>
<tr>
<td>Critically review the literature</td>
<td>• Literature was critically reviewed for many projects. For example, literature on the role of race and ethnicity in the incidence and treatment of mental health difficulties was reviewed in the Older People essay and literature on school refusal was critically reviewed in the Major Research Project.</td>
<td>Aug 03 \ Jan 04</td>
</tr>
<tr>
<td>Formulate a specific research question</td>
<td>• A specific research question was formulated for the Major Research Project on the basis of discussions with the university supervisor and experts in the field.</td>
<td>Nov 2002</td>
</tr>
<tr>
<td>Write a brief research proposal</td>
<td>• Prepared a brief research proposal on designing and piloting a pre-initial assessment questionnaire to screen out inappropriate referrals.</td>
<td>Nov 2001 \ Nov 2002</td>
</tr>
<tr>
<td></td>
<td>• A brief research proposal was written for the Major Research Project and was submitted to the university research tutors.</td>
<td></td>
</tr>
<tr>
<td>Research Skill/Experience</td>
<td>Description of how research skill/experience acquired</td>
<td>Date research skill/experience acquired</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
</tbody>
</table>
| **Write a detailed proposal/protocol**                 | • A detailed research proposal was written for the Service Related Research Project after consultation with the research supervisor and submitted to the university research tutors.  
• A detailed research proposal was written for the Major Research Project and submitted to the university research tutors.  
• A very detailed proposal of the Major Research Project was written for the West Kent NHS and Social Care Trust Ethics Committee. | • Dec 2001  
• Dec 2002  
• Feb 2003 |
| **Obtain appropriate supervision/collaboration for research** | • Field supervision was obtained for the Service Related Research Project.  
• For the Qualitative Research Project there was collaboration with other trainees over the design, conduct and analysis of the research.  
• The Major Research Project was supervised from the development of the research idea through to the write up of the project by the university and field supervisor | • Nov 2001  
• April 2003  
• Nov 2002 – July 2004 |
| **Write a participant information sheet and consent form** | • Participant Information Sheets and Consent Forms were written for school refusers, school attenders and their parents/guardians for the Major Research Project.                                                                                              | • Jan 2003 |
| **Judge ethical issues in research and amend plans accordingly** | • Ethical issues were considered in all research undertaken. Following feedback from West Kent NHS and Social Care Trust Ethics Committee, some minor amendments were made to the Major Research Project.                                                                 | • March 2003 |
| **Obtain approval from a research ethics committee** | • Research approval was granted for the Major Research Project from West Kent NHS and Social Care Trust Ethics Committee and Research and Development Committee.  
• Research approval was granted for the Major Research Project from the Ethics Committee at Surrey University. | • March 2003  
• May 2003 |
<table>
<thead>
<tr>
<th>Research Skill/Experience</th>
<th>Description of how research skill/experience acquired</th>
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</table>
| Collect data from research participants   | • Clinical Psychologists were interviewed, pre and post the construction and pilot of a screening questionnaire as part of the Service Related Research Project.  
• Clients in an adult mental health service completed screening questionnaires as part of the Service Related Research Project.  
• A focus group with trainees was run, transcribed and analysed as part of the Qualitative Research project.  
• School refusers and attenders were interviewed for the Major Research Project.                                                                                                                                                                                                                                                                                                                                 | • Jan - March 2002.  
• Feb – March 2002.  
• April 2003  
| Set up a data file                        | • A data file was set up in SPSS for the Major Research Project.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | • Jan 2004.                               |
| Analyse quantitative data                 | • SPSS Tables, Syntax and Output files were used to store and analyse data collected for the Major Research Project. Data analysis involved descriptive statistics, T-tests and Mann Whitney tests.                                                                                                                                                                                                                                                                                                                                                                                | • Jan-June 2004.                           |
| Analyse qualitative data                  | • A focus group that lasted an hour and a half was held, transcribed and analysed. The method was co-operative inquiry and Interpretive Phenomenological Analysis was used to analyse the transcripts.                                                                                                                                                                                                                                                                                                                                                                      | • March-May 2003.                           |
| Summarise results in figures/graphs       | • Graphs and figures were used in case reports to describe outcome data and client's progress through therapy.  
• Figures were used in the Service Related Research Project, Qualitative Research Project and the Major Research Project.                                                                                                                                                                                                                                                                                                                                                                                                      | • Year 1 (2001-2002).  
• Year 2 (2002-2003)  
• Year 3 (2003-2004). |
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<th>Research Skill/Experience</th>
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</table>
| Interpret results from data analysis | - Results of an item analysis and responses to semi-structured interviews were discussed and implications were reflected on as part of the Service Related Research Project.  
- Results from the quantitative analysis were interpreted and implications for clinical practice were reflected upon as part of the Major Research Project. | - June 2002.  
| Present research findings/plans to an audience | - Two presentations of the Service Related Research Project were delivered – one to Psychologists in the service where the research was conducted and the other to First Year trainees.  
- Two presentations of the Major Research Project were delivered: one to Second Year Trainees and another to multi disciplinary team at a Children Adolescent Mental Health Service. | - March 2002  
- Sept. 2003  
- Oct 2003 |
| Produce a written report on a research project | - The Service Related Research Project was written and submitted to the university.  
- The Qualitative Research Project was written and submitted to the university.  
- The Major Research Project was written and submitted to the university. | - Aug. 2002  
- May 2003  
- July 2004 |
<p>| Defend research project at an oral examination | - The Major Research Project is to be defended at the viva voce examination. | - September 2004. |
| Submit research report for publication in a journal/book | - The Qualitative Research Project is in the process if being submitted for publication. | - August 2004 |</p>
<table>
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<th>Research Skill/Experience</th>
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</table>
• Jul 2003  
• Jan 2004 |
A Comparison of School Refusers' and School Attenders' Attachment Relationships to Their Main Caregivers and Peers.
1. Abstract

Objective: This study compared school refusers' and school attenders' scores on the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987) which assesses attachment to mother, father, and peers. It was hypothesised that school refusers would obtain statistically significantly lower scores on each of three scales: attachment to mother, father and peers, than school attenders. Each of the three scales contained the following subscales: trust, communication, and alienation.

Participants: There were 79 participants: 16 were school refusers recruited from Child and Adolescent Mental Health Services (CAMHS). The remaining 63 were school attenders recruited from five secondary schools ranging from grammar to community college. All participants were aged between 11 and 15 years.

Results: There was no significant difference between school refusers' and attenders' scores on the attachment to mother measure. Although there was no significant difference between the groups in total scores of attachment to father, school refusers obtained statistically significantly lower scores than attenders on the trust of father subscale. School refusers obtained statistically significantly higher scores than attenders on the communication with father subscale. School refusers obtained statistically significantly lower scores than attenders on the measure of attachment to peers.

Conclusions: Psychoanalytic ideas were used to link school refusers' lower levels of trust with fathers and lower levels of attachment to peers. From a systemic perspective the significant results were considered to reflect an undermined secure family base of school refusers. The concept of the secure family base may be embedded within complex relationships between other factors shown to influence school refusal. Although this study does not provide evidence for these speculations it is argued that the notion of attachment can be usefully applied to school contexts if viewed as one factor amongst many, which together in their complex interaction influence school attendance and refusal.
2. Introduction

2.1 Overview of School Refusal

This chapter aims to introduce the concepts of school refusal and attachment theory as well as explain why these phenomena are worthy of investigation. An overview of the research into school refusal, including factors related to school refusal and theoretical approaches relating to the problem are presented. Attachment theory is described and constructively criticised, and finally the rationale for the current study is outlined.

One percent of school-aged children and five percent of clinic-referred children experience school refusal (Burke & Silverman, 1987). Whilst school refusal is not influenced by gender, level of intelligence, presence of a learning disability, socio-economic status or family composition, there is a greater prevalence in the pre-adolescent and adolescent age range (Heyne, Rollings, King & Tonge 2002).

2.1.i The Consequences of School non-attendance

Research has indicated numerous consequences of long absences from school: in the short-term, low grades, and friendship and family relationship problems (Last & Strauss, 1990); in the longer-term, school refusers may find it difficult to pursue further or higher education, have work and socialising difficulties, and even be at greater risk of future psychological difficulties (Buitelaar, van Andel, Duyx & van Strien, 1994; Flakierska-Praquin, Lindstrom & Gillberg, 1997; Kearney & Albano, 2000). Heyne et al., (2002) reported that the shorter the absence, the less anxiety-provoking the return to school. Reasons for this include: disturbances in friendships, losing touch with friends, difficulty in explaining prolonged absences and concerns about having fallen behind due to increasing amounts of missed work.
2.1.ii Definitions of School Refusal

2.1.ii.a Initial Definitions

In 1932 Broadwin observed that some truants consistently avoided school and appeared to be 'neurotic'. Partridge (1939) proposed that anxiety displayed by truants was due to overprotection between parent and child. The term 'school phobia' was introduced by Johnson, Faltein, Szurek & Svenden (1941) who claimed that school phobics were predisposed to phobia, and had an enmeshed, mutually dependent and hostile relationship with their mother (Johnson et al., 1941). The child, being prone to regressive dependency, found it extremely difficult to break free from this situation (Johnson et al., 1941). The term 'school phobia' implies an irrational fear of schools, in the same way that a dog phobia implies an irrational fear of dogs. The term 'school refusal' is now used as it does not assume an underlying psychopathology, is less definitive with regard to aetiology, diagnosis or prognosis and is thus more inclusive (Heyne et al., 2002). The term 'school refusal' will therefore be used throughout this report.

2.1.ii.b Current Definitions of School Refusal

There are no clear diagnostic criteria for school refusal in either the International Classification of Mental and Behavioural Disorders (World Health Organisation, 1992) or the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (American Psychiatric Association, 1994). This research therefore adopted Heyne et al.'s (2002) criteria set out in table 1 as recommended by the British Psychological Society (Heyne et al., 2002, p.3).
Table 1: Heyne et al.'s (2002) criteria for school refusal

<table>
<thead>
<tr>
<th>Criteria Number</th>
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<tbody>
<tr>
<td>1</td>
<td>&quot;Severe difficulty in attending school, often amounting to prolonged absence.&quot;</td>
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<tr>
<td>2</td>
<td>&quot;When faced with the prospect of going to school with reasonable parental pressure, either severe emotional upset, shown by such symptoms as excessive fearfulness, undue temper and misery, or complaints of physical illness which do not have obvious physical cause or are thought to have an emotional basis.&quot;</td>
</tr>
<tr>
<td>3</td>
<td>&quot;At some stage in the course of the attendance problem, the student stays at home with the knowledge of the parents when the school refuser should be at school.&quot;</td>
</tr>
<tr>
<td>4</td>
<td>&quot;Absence of conduct disorder.&quot;</td>
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2.1.iii Factors Related to School Refusal

Research has identified numerous factors associated with school refusal and these are grouped here as child, relationship and school factors.

2.1.iii.a Child Factors

Some of the research into school refusal has focused on the psychopathology of this client group, highlighting the presence of depression and anxiety (Egger, Costello & Angold, 2003; Bernstein et al., 1997). Last and Strauss (1990) assessed 63 school refusers aged 7-17 years and identified that 38% had separation anxiety disorder, 30% had social phobia, 22% had simple phobia, 6% had panic disorder, and 3% had post-traumatic stress disorder, according to Diagnostic Statistical Manual Third Edition Revised (American, Psychiatric Association, 1987, cited in Last & Strauss, 1990) criteria. Heyne, King, Tonge & Cooper (2001) reported that almost a half of school refusers experience sub-clinical depression - i.e. symptoms of depression. Referrals to
a school phobia treatment clinic have been divided into three groups: depressive disorder; anxiety disorder; anxiety disorder and depressive disorder combined (Bernstein, Garfinkel & Borchardt 1990)

Last & Strauss (1990) found separation anxiety disorder to be the principal diagnosis given to school refusers and mothers of the separation anxious often refused to go to school themselves (Last & Strauss, 1990). Almost 75% of school refusers have a parent who has been treated for a psychological difficulty (Egger et al. 2003; Martin, Carrol, Bouvard, Lepine & Mouren-Simeoni 1999).

2.1.iii.b Relationship Factors and the Family
As reported above, school refusers have been found to be separation anxious (Johnson et al. 1941; Waldfogel, Coolidge & Hahn 1957). The mother-child relationship has been described as oppressive, over-protective and 41% of school refusers' families were unable to recognise and nurture their children's needs for autonomy and separateness (Waldron, Shirer, Stone & Tobin (1975). Other family relationship factors include: "psychological problems in the parent; family breakdown, separation and divorce; traumatic events at home such as bereavement, violence and abuse; situations where the child is required to look after a younger sibling" (Archer, Filmer-Sankey & Fletcher-Campbell, 2003, p.14).

Family beliefs and experiences are likely to influence the way the family responds to a child starting school which is a big step in the family life cycle (Lindsey, 1994). It may be seen positively, in terms of a great opportunity for learning and developing independence, or negatively as "the re-experiencing of loss by death or separation in current or previous generations; ... an invasion of an antagonistic outside world, a legal imposition of a hostile or alien culture or environment" (Lindsey, 1994, p.117). It may be that school refusers see starting school and the transition from Primary to Secondary school (which often coincides with the onset of school refusal) in this latter way.
2.1.iii.c School Factors

Dowling & Osborne (1994) have identified a variety of school factors that contribute to school refusal including bullying, transition from Primary to Secondary school, poor school structure and poor school communication with the family.

Bullying

Bullying can lead to school refusal (Skiba, 2004). Archer et al. (2003) recommend that all schools have anti-bullying policies to prevent/ manage bullying to improve the school culture and reduce the rate of school refusers.

Transition from Primary to Secondary School

Onset of school refusal often coincides with transition to Secondary school (Berg, 1997). Students feel overwhelmed by: a much larger building; many more students; crowded noisy corridors; having more teachers and having to switch classrooms for different lessons on a regular basis (Archer et al. 2003). Parents communicate less with teachers in Secondary schools Dowling & Pound, 1994). Taylor (1994) argued that the distress caused by this transition can be minimised if: Primary and Secondary schools communicate regularly; young people visit the Secondary school before starting; and fewer teachers and classrooms are used in Year Seven (first year of secondary).

Poor Communication with the family

Young people are a member of two overlapping systems: the family and the school (Dowling, 1994). When a child refuses to go to school each system feels disappointed and can blame each other, which can leave a child feeling "either very anxious because previous sources of support have demolished each other so neither can be depended on, or uneasily powerful because the child can manipulate the authority figures in his/her life... such misunderstanding between school and family may lead to school refusal..." Dowling & Pound (1994, p.69). Parents and teachers can feel blamed by the other party and their discussions can create further distance between them (Dawson & McHugh 1994). Dowling & Pound (1994) stressed the importance of nurturing parent teacher relations from the outset and the benefits of joint interviews between teachers and parents, facilitated by a therapist which inform
teachers of family stresses and enable parents to hear the concerns of the school in a calm situation, enabling joint problem-solving.

Poor School Structures
The school system consists of many subsystems (e.g. Maths department; English department) and these subsystems need to be able to communicate and manage power struggles, processes that are aided by a good school structure (Taylor, 1994). A poor school structure, for example where the head teacher of a large school is very controlling and form tutors have little power, is problematic since the Head will be unable to know each student individually and intervene as problems with absence arise (Dowling & Pound, 1994). Schools with good structures may have staff "specifically responsible for monitoring attendance" and appropriate pastoral care or units for those struggling to attend school (Archer et al. 2003). Staff may lack the training to deal with school refusal and group dynamics between subsystems may make it difficult to share information and provide support across subsystems (Dowling & Pound, 1994).

2.2. Theoretical Approaches

2.2.i. Behavioural Approach
Behavioural understandings consider child, family, and school factors. Behaviourists have considered which environmental consequences (reinforcers) maintain observed behavioural patterns (school refusing behaviour). Kearney & Albano (2000) claimed that an individual's school refusal can best be understood through functional analysis and identification of reinforcing patterns. Operant conditioning principles suggest that positive and negative reinforcers can establish and maintain behaviour. The 'behaviour' can be negatively reinforced if the young person avoids distress that they usually experience if forced to attend school and if they are able to miss tests or other "evaluative situations" (Kearney & Albano, 2000 p.3). Alternatively, school refusal may be "positively reinforced", maintained by the response it evokes in parents and carers – the additional attention it brings and secondary gains, such as ability to
partake in more enjoyable activities if they stay at home rather than go to school e.g. listen to their CDs, watch television or play computer games (Kearney & Albano, 2000). According to these authors, one or more of these reasons can maintain school refusal in any one individual.

Principles of classical conditioning could be applied to school refusal since environmental stimuli could come to exert conditioned effects. Garvey & Hegrenes (1966, cited in Pilkington & Piersel, 1991) linked behavioural principles with separation anxiety theory (described in the 'Analytic and dynamic approach' section). Regular warnings of leaving, by mother, lead the child to become verbally conditioned to fear mother leaving (Garvey & Hegrenes, 1966, cited in Pilkington & Piersel, 1991). If the mother's comments focus on going whilst the child is at school, the school, initially a neutral stimulus, would become verbally conditioned to concerns about mother leaving (Garvey & Hegrenes, 1966, cited in Pilkington & Piersel, 1991). Consequently, the child refuses to go to school, stays at home to reduce anxiety (negative reinforcement) and positive reinforcement of attention and being able to engage in pleasurable activities such as watching the television, intensifies the school refusal behaviour.

2.2.ii. Cognitive Approach

Cognitive understandings focus more on child factors (cognitions) and parental cognitions. Whilst a range of cognitive models exist, they generally assume that a young person has irrational fears about attending school. Heyne et al. (2001, p.725) described a few common cognitions of anxious school refusers which maintain school refusal: "an overestimation of the probability of negative events (e.g. mother falling ill while I am at school); underestimation of one's ability to cope (e.g. I won't be able to give the talk in front of the class); regarding negative events as catastrophic (e.g. it is awful and unbearable when the teacher raises her voice)". The cognitive model may assume that such thoughts are related to underlying core beliefs that may be activated by a critical incident, possibly related to school or home life.
Applications of cognitive and behavioural models

In combination, Cognitive-Behavioural models assume "school refusal can be viewed as a complex set of learned responses that have specific affective, behavioural and cognitive referents" (Ollendick & King, 1998, p.17). Cognitive Behavioural Therapy (CBT), identifies and challenges distorted cognitions and attempts to change behaviour patterns. CBT for school refusal should involve child work, challenging distorted thoughts, exposure, relaxation training and developing social skills; parent and schoolwork may involve the development of behavioural management techniques (Heyne et al. 2002).

CBT is currently the most appropriate treatment for school refusal as it is widely researched compared with alternatives (Heyne et al., 2001). However, the evidence base has been criticised, for example, Blagg & Yule (1984, cited in King & Bernstein, 2001) failed to use randomisation. Last, Hansen & Franco, (1998, cited in King & Bernstein, 2001) found CBT was no more effective than educational support therapy, an approach which used CBT-like tools but "therapists refrained from encouraging children to confront their fears or teaching them how to modify their thoughts" (King & Bernstein, 2001 p.202).

King, Tonge, Heyne & Ollendick (2000) reviewed research on cognitive behavioural treatment of school refusal and concluded that "although cognitive behaviour therapy appears to be a useful treatment for school refusal, further research is needed before it can be considered as having "well-established" empirical status"(p.495). However, perhaps most importantly, there appear to be hardly any studies that investigate how effective cognitive, behavioural and cognitive-behavioural theories are in developing an understanding of the aetiology of school refusal.

2.2.iii Medical Approach

The medical model also relates to child factors and views school refusal as a symptom of a broader psychiatric/psychological problem such as depression or anxiety (Bernstein et al., 1990). Research has highlighted the benefits for school refusers of taking medication, such as reduced frequency and severity of panic attacks
Major Research Project

(Gittleman-Klein, 1975; cited in Burke & Silverman, 1987). However, there does not appear to be a clear medical aetiological understanding of school refusal.

2.2.iv Systemic Approach

Systemic approaches acknowledge the importance of both the school system and the family system in the onset and maintenance of school refusal and often carry out joint work with the family and school (Dowling 1994). The joint systems approach aims to "facilitate communication between school, staff and family members. To clarify differences in perception of the problem by focusing on how it occurs rather than why. To negotiate commonly agreed goals and to begin to explore specific steps towards change." (Dowling, 1994, p.15)

Dowling & Osborne (1994) stress the importance of the concepts of mirroring and triangulation and highlight the fact that family dynamics can be mirrored at the school. They cite an example of a school refusing boy triangulated between his mother and grandmother. It was unclear who was the main caregiver and at school it was equally unclear who was most powerful, a new head teacher or an established deputy head (Dowling & Osborne 1994). This could be confusing for a child and "in each case the secondary gains of the situation kept it going. Such duplication of a problematic situation in both contexts reinforces the dysfunctional pattern and indicates to the practitioner that her interventions should give priority to a change in alignment " (Dowling & Osborne 1994, p.171).

2.2.v. Analytic and Dynamic Approach

Separation anxiety has been considered the cause of school refusal and psychodynamic theorists have often focused on mother-child relationships and separation anxiety (Oelsner, 2003). Johnson et al. (1941) argued three factors need to be present for the development of school refusal: a poorly resolved dependency relationship of child to mother, acute anxiety in the child and a rise in the mother's anxiety caused by either marital or financial difficulties or 'unfair' demands placed on her. Consequently, the mother is ambivalent and encourages the child to be over-
dependent for her sake. This leads to a vicious circle; the child becomes very dependent and makes numerous demands on the mother, leaving the mother hostile and then guilty about her hostility, and therefore overprotective. The child begrudges the mother's overindulgence at an unconscious level (Pilkington & Piersel, 1991). "Dependency and hostility in the child inhibit ego development, and his or her anxiety becomes displaced onto the teacher or school" (Pilkington & Piersel, 1991, p.292).

Cohen & Lwow (2004, p.307) have developed a model which considers such parent–child dynamics through "integrating theoretical conceptualisations from bio-psycho-social systems theory and from relational psychoanalysis". In therapy, psychoanalysts are increasingly acknowledging the role of affect and engagement in promoting "increased resilience in the child when faced with emotional distress and help arrest malignant intrapsychic and interpersonal development" (Barish, 2004, p.385).

Pilkington & Piersel (1991) highlighted weaknesses with the separation anxiety theory such as lack of a control group, case study design and lack of detailed methodology preventing external assessment from an independent researcher (Pilkington & Piersel, 1991). Age at onset and ease with which school refusers can separate from parents in non-school situations also raise questions for the separation anxiety theory (Pilkington & Piersel, 1991).

2.2.vi. Developmental Approach

Successful adjustment to school and home is linked to the degree of correlation/similarity between self-concept and ideal self (Ausbel et al., 1954 cited in Herbert, 1998). Cognitive, social and emotional development has been linked since those who perform poorly at school are more likely to have poor self concepts and feel defensive and lonely (Ausbel et al. 1954, cited in Herbert, 1998). Those with a poor self concept are likely to have low self-esteem, be sensitive to challenge and feel self-conscious and isolated (Herbert, 1998), factors which may contribute to school refusal. Thus children at a different stage of cognitive development from their peers may experience repercussions to their social and emotional development making them vulnerable to developing school refusal. Similarly, rate of physical development may be a factor in
school refusal as very early or very late developers may be teased, picked, on or even bullied by peers (Herbert, 1998).

Attachment theory has been used to explore children's development and can be adopted within a psychodynamic, systemic and even cognitive framework to further our understanding of clinical issues. In the sections that follow, attachment theory is described, its strengths and weaknesses are outlined and the rationale for exploring the attachment relationships of school refusers in the current study is set out.

2.3. Attachment Theory

2.3.i. Introduction to Attachment Theory

Bowlby (1973, 1998), the creator of attachment theory, was interested in studying family relationships scientifically and therefore focused on the child-parent dyad (Marvin, 2003). He observed attachment behaviour which is defined as "any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued or sick and is assuaged by comforting and caregiving" (Bowlby, 1988, p.26-27).

2.3.i.a Parenting as the Secure Base

According to Bowlby (1988), the key element of parenting was the provision of a 'secure base'. The child was able to explore the world if s/he was confident that the secure base was available to him/her when anxious or upset (Bowlby, 1988). Initially, a young child would only travel a little distance and regularly return to their parents but, as the child learnt that they could rely on the caregiver to be there, they travelled further distances and spent longer away from the parents (Bowlby, 1988). Attachment has a protective function since it ensures that we remain in easy access to someone who can help us in an emergency (Bowlby, 1988).
2.3.i.b Internal Working Models

Bowlby (1988) theorised that during the first few years of life, a child would begin to internalise external experience of attachment relationships and "internal working models" are formed. A child develops internal working models of him/herself and the world, which incorporates his/her parents (Bowlby, 1973, 1998). These are based on real life experiences and the model of the self reflects the parents' images of the child demonstrated in the parent's communication and behaviour (Bowlby, 1988). The models determine how the child feels about each parent and him/herself, the child's expectations of parent's behaviour, and how to behave towards them (Bowlby, 1988). Where the quality of attachment relationship is good (secure), internal models will be updated to incorporate new information and experiences. Where the quality of attachment is poor (insecure), defences operate which exclude discrepant information and experiences, and the internal model is not updated. Consequently, initial interaction patterns become habitual and generalised and are likely to influence all future relationships at an unconscious level (Bowlby, 1988).

The vagueness of the internal working model (IWM) and the fact that there are many alternative definitions for the IWM make it very difficult to scientifically test this concept (Dunn 1993). The assumption that twelve-month-old infants had the cognitive capacity to represent different features of relationships has also been questioned (Dunn 1993). Bretherton & Munholland (1999, p.108), however claimed the concept of the internal working model in attachment relationships is very valuable and they call for a "more process orientated approach to the study of working models as they are constructed, developed and revised through participation in attachment relationships." Rothbaum, Weisz, Pott, Miyake & Morelli (2000) argued that attachment theory has provided many testable hypotheses.
2.3.ii. The Strange Situation and Attachment Styles

Theorists have argued that given the limited number of possible responses of a caregiver to a child's proximity seeking behaviour, there can only be a finite number of attachment styles. Ainsworth, Blehar, Waters & Wall (1978) developed the 'Strange Situation' (SS), an experimental scenario in which a child was separated from their main caregiver, introduced to a stranger and subsequently re-united with their caregiver. Through observing several parent and child participants in this scenario, Ainsworth et al. (1978) identified three main styles of attachment (see table 3 below), the Disorganised-Disorientated style was later identified by Main & Solomon (1990).

Table 2: Attachment Styles

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Attachment Classification</th>
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<tr>
<td>B</td>
<td>Secure</td>
</tr>
<tr>
<td>A</td>
<td>Insecure-Avoidant</td>
</tr>
<tr>
<td>C</td>
<td>Insecure-Ambivalent</td>
</tr>
<tr>
<td>D</td>
<td>Disorganised-Disorientated</td>
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A secure attachment will develop if the caregiver is reliably responsive to the child's needs. An avoidant or ambivalent pattern will result if the caregiver completely fails to respond to the child's needs, or if the caregiver is only responsive sometimes, and thus, the child cannot trust that the caregiver will respond to a need.

Solomon & George (1999) highlight the fact that Ainsworth's classification was based on a study conducted over thirty years ago and had a sample of only 23 mother-child dyads, all of whom were middle class. Findings from cross-cultural and day care research question the validity of the SS with certain groups. For example, Japanese babies have been observed to react differently from U.S. babies in the SS, displaying behaviour which would be categorised as insecure-avoidant (Rothbaum et al. 2000). However this is misleading since in Japanese culture, such behaviour is seen as adaptive and is not associated with incompetence (as it is in the US) (Rothbaum et al. 2000). Care-giving practices reflect cultural values; Japanese parents anticipate their infant needs compared to American parents who wait for the infant to communicate their needs, Rothbaum et al. (2002, p.1097) argue: "the different expressions of sensitivity and responsiveness suggest that Japanese caregivers' responsiveness has more to do with emotional closeness and the parent's role in helping infants regulate..."
their emotional states, whereas for caregivers in the United States, responsiveness has more to do with meeting children's need to assert their personal desires ... respecting children's autonomous efforts to satisfy their own needs." Sensitivity in Japanese culture is responsivity to an infant's social engagement needs, in the U.S. it is seen as responsivity to an infant's individuation needs (Rothbaum et al., 2000). These observations highlight a major criticism of attachment theory; that it is stooped in Western culture, ideals and values and when applied to other cultures can lead to misguided conclusions, this is further explored under section 2.4.i 'the universality of attachment theory' (Rothbaum et al. 2000). Within culture differences have also been observed, for example, children who are in day care are likely to respond differently in the SS than those who are not regularly separated from their mother and "what appears to be avoidance in the strange situation may instead be independence" (Howes, 1999, p.684).

Dunn (1993) argued that attachment researchers are not always clear about what exactly is being measured in the SS, it could measure differences in the children, rather than in the child-parent relationship. Since behaviour in the SS has been shown to change in accordance with family circumstances, the SS can only measure 'current' parent-child attachment security (Dunn, 1993). The use of categories rather than dimensions on the SS's coding system has been questioned by many and this is explored later on under the sub-heading 'constructive criticism of the typological approach to attachment'.

A strength of the SS is that it has been shown to have reliability and predictive validity in the West (Solomon & George 1999).

2.3.iii. Individual Experience and Attachment Narrative

The SS is clearly a behavioural measure designed for use with infants, in contrast, attachment narratives tell an individual's story about their emotional experience of attachment relationships beyond infancy. Bowlby (1988) claimed that attachment styles become entrenched and are then not conscious and are incredibly difficult to change. More recently, researchers and clinicians have stressed the flexibility of
attachments, that despite traumatic childhoods some people can develop (or 'earn') secure attachments in adulthood, through for example, the experience of a happy marriage or therapy (Byng-Hall, 1999). The Adult Attachment Interview (AAI George, Kaplan & Main, 1984, 1996) has been widely used to investigate attachment in adulthood.

Those that tell a coherent and consistent story about their childhood are said to have a coherent narrative and research indicates these adults are securely attached with securely attached children (Byng-Hall, 2002). Securely attached children tend to have parents with a coherent narrative that conveys "a consistent and coherent view of what happens in relationships" (Byng-Hall, 1997, p.107). An incoherent narrative will result if one has many different understandings of the same situation and if children witness something but are told something else, both of these things can happen when parents separate and divorce (Byng-Hall, 1997). The ability to think about one's thinking ("meta-cognitive monitoring") is therefore a prerequisite to a coherent narrative since any two perceptions of relationships need to be assessed for compatibility and some ideas will need to be dismissed in order to be coherent and consistent (Byng-Hall, 1997).

Dunn (1993) argued that the coherence with which a parent talks about their own childhood (attachment narrative) is strongly influenced by their current circumstances, a "causal link" between a mother's attachment relationships and her child's attachment relationship could not be assumed since "having an easy relationship with a securely attached child may well contribute to a woman's rosy view of life, including her perspective on her own childhood" (Dunn 1993, p.82).

However the concept of attachment narratives has been very useful in working clinically with families (Byng-Hall, 1999).
2.3.iv Beyond The Mother- Child Dyad
Traditionally attachment research focused on the mother-child dyad but attachment theory has evolved in accordance with societal change and has considered the important roles of fathers, siblings and the complexity of multiple attachments in single parent families and two-working parent families that require day care.

2.3.iv.a Attachment with Siblings
Attachments relationships between siblings have been observed through the use of the Strange Situation (Marvin, 2003). Stewart & Marvin (1984, cited in Marvin, 2003, p.11) found that if the older sibling was aged four or more, "that older sibling tended to play a protective role toward the younger sibling, that the younger sibling actively used the older sibling as a haven of safety and that mothers of those sibling dyads tended to ask the older sibling to help out when she left the room." However when the child was under three and a half, both children would become distressed and the older child would not be able to act as an attachment figure to the younger (Marvin, 2003). In the school setting, siblings can act as an attachment figure, providing support to stay in school. Equally siblings, in their role of attachment figure could stay at home to look after a sibling and as a result may develop school refusal (Archer et al. 2003). In families with insecure attachments, siblings can compete with each other for their parent's attention (Mackey, 2003). It has been theorised that children who have insecure attachments to their parents will have insecure attachments to their siblings (Dunn, 1993).

The theory that children with insecure attachments to their parents will also have insecure attachments to their siblings has been questioned by Dunn (1993, p.90) who argued that whilst there may be similarities between these relationships, both child-parent and child-sibling relationships are complex and multi-faceted and that "although some facets of each relationship will show links with aspects of the other, we should not look for simple equivalences". In reflecting on developmental changes that occur in the sibling relationship, Dunn (1993) questioned the notion that sibling relationships should be seen as an attachment relationship with an unchanging internal working model since degree of conflict is influenced by developmental stage and life events, such as marital break-up or changing school (Dunn, 1993).
The concept of attachment between siblings is useful in therapy, for example siblings can be encouraged to see each other as allies, and to support each other in the absence of parental attention (Mackey, 2003).

2.3.iv.b The Complexity of Multiple Attachments
Byng-Hall (1999) stressed the importance of looking at triadic, compared to dyadic relationships: they provide information about alliances between family members and desires to be included or excluded. Furthermore "problems in one relationship can be rerouted through another relationship; for example parental tension can be lessened by directing conflict toward a child." (Byng-Hall, 1999, p.626).

In addressing family stories and narratives, systemic therapists highlight the complexity of multiple attachments (Byng-Hall, 1999). Family members can have different attachment styles and engage in different behaviours, such as 'clinging' and 'distancing' which can be confusing and lead to difficult family dynamics (Byng-Hall, 1997). For example, one parent may distance themselves from the other and the other parent responds by clinging to their partner which leads to further distancing which can go on in a vicious circle. Hearing each parents' conflicting interpretation of the situation can be confusing for children and can reduce the security of the family, but this can be addressed within the context of family therapy (Byng-Hall, 1999). Indeed family therapy can identify factors "that undermine security felt in the family... exploring contrasting styles of narrative and how to link them into a coherent story (Byng-Hall, 1997, p.113).

Attachment patterns in families have been explored through considering aspects of family relationships shared by all its members, such as family beliefs and behaviour patterns (Byng-Hall, 1999). A 'family script' is "composed of the family's shared expectations of how family roles are to be performed in various contexts (including that of attachment / caregiving)" (Byng-Hall, 1999, p.626). Each family member will know their own role and those of others (Byng-Hall, 2002).
In insecure families, a 'parentification script' may exist, where child-parent roles can be switched so that the child is caring for the parent (Byng-Hall, 2002). According to Byng-Hall (2002) this type of family script, which may be transient or longer term, and will result from problematic parental attachment histories. In the long term, parentified children can experience depression, social isolation and develop symptoms which hide what is really happening (Byng-Hall, 2002). Byng-Hall (2002) reported that this can happen with school refusal, attention is focused on the child's absence from school rather than the parentification which is occurring.

A variety of adults can act as attachment figures to young people: grandparents, aunts, uncles, carers, even teachers can provide security when parents cannot (Cretzmeyer, 2003). In these situations, it is recommended that such attachment figures be included in therapy "and coached on how to develop a more supportive relationship with the adolescent without further threatening the adolescent's relationship to the parents" (Mackey, 2003, p.104)

### 2.3.iv.c Attachment with Fathers

Fathers are seen (within the psychodynamic field) as gatekeepers to the social world and as providing relationships with the child that can be used as a template for all future relationships. Ducharme, Doyle & Markiewicz (2002) reported that young people with a secure attachment to their father got on better with their peers than youngsters with an insecure attachment to their fathers. Steele (2002, p.520) argued it is the father-child relationship that predicts the child's "perceived functioning in peer relationships and overall self-report of behavioural problems at the onset of adolescence." Furthermore research by Williams (2003) indicated a correlation between father-child attachment security with internalising and externalising behavioural problems in their children. It is therefore possible that attachment to fathers is a factor in school refusal.

Steele, Steele & Fonagy, (1996 cited in Steele, 2002) examined mothers with their 12-month olds in the SS. Six months later fathers were observed with these infants in the same situation (Mothers and fathers had been interviewed using the AAI (George et
al., 1985) before their child had been born. The outcome of the mother's AAI predicted the quality of mother-infant attachment and the quality of father-infant attachment relationship was predicted by father's AAI (Steele, 2002). Firstly the psychoanalytic theory and secondly, research into father's play will be presented to explain why attachment to fathers is important.

Firstly, within the psychoanalytic field, fathers have an important role in the separation-individuation process, in fostering autonomy and independent functioning (Henderson, 1982; Target & Fonagy, 2001). The child's initial relationship (with their mother) cannot be represented until the presence of a second object is available, when the father can perceive the child's experience of its relationship with its mother, represent it in his own mind and then offer it to the child (Target & Fonagy, 2001). The mother can reciprocate this process so the child can have two internalised representations that are separate from the self (Target & Fonagy, 2001). However, if the parents inaccurately represent the relationships, the process breaks down and the relationship becomes represented within the child as part of the self, rather than as a relationship. Henderson (1982) stressed a child's relationship with its father may act as a template for future relationships such as those with peers (Ducharme et al. 2002).

Winnicott (1957) argued that the father has an important role in supporting his partner in her mothering and also in introducing the child to the external world, particularly through play. More recently, Verschueren & Marcoen (1999, p.183) have shown the child-mother attachment was a better predictor "of the child's positiveness of self" and the child-father attachment was a better predictor of "anxious, withdrawn behavioural problems".

Secondly, research has also highlighted father's play-sensitivity and the role of fathers as a link between the child and the outside world across many different countries (Grossman et al. 2002). Fathers typically encourage more vigorous play, provide a sense of security during challenging tasks and, in doing so, challenge their child's ability to adapt to new elements of their culture (Grossman et al., 2002). Mothers may be more able to provide the 'secure base', fathers may be more likely to offer 'secure exploration' through providing sensitive support during challenging
exploratory play (Grossman et al., 2002). Emotionally secure exploration results from sensitivity to expressed emotion in the child coupled with support and gentle challenging. Whilst engaged in exploratory activity a child will return to its secure base (often the mother) if afraid but if a "stronger and wiser companion to its challenging tasks" is available to provide "sensitive support on the spot", leaving the challenging play to return to the secure base is unnecessary (Grossman et al., 2002, p.325). Thus a child may be more 'clingy' in single parent families if no-one offers the child secure exploration. In many single parent families another figure is available (e.g. grandparent or aunt) to provide secure exploration.

2.3.iv.d Attachments in Single Parent Families
Single parent families, like two-parent families, may be secure or insecure (Byng-Hall, 2002). If a family goes from a two to a one parent family parentification (where child-parent roles are switched so that the child is caring for the parent) can occur with one child (often the eldest) caring for the remaining parent (Byng-Hall, 2002). If the parent can recover quickly or access support from other adults then the parentification will not go on for long (Byng-Hall, 2002). Research has been conducted into the effects on children of parents separating and divorcing. The effects of divorce (problems with school, friends and self-esteem) are likely to be minimised when the children maintain good relationships with both parents and conflict between parents ends after divorce (Dowling & Gorrell-Barnes, 1999). If children are to develop a coherent story about their parents separation, they need to "mourn the family as it was", which can be difficult for parents to understand if they considered life before the separation as terrible, but both the mother and the father must be consistent in their approach to parenting (Dowling & Gorrell-Barnes, 1999, p.41). In couple separations the children can be left feeling unable to share their feelings with either parent for fear of upsetting them; in these cases a therapist can act as a secure base, listening to the children's feelings before they express them directly to the parents (Dowling & Gorrell-Barnes, 1999). The children also need to be given a clear rationale for the separation, otherwise they are likely to believe they are responsible and strive to get their parents back together and if they hear different rationales from each parent they may develop incoherent narratives (Dowling & Gorrell-Barnes, 1999).
2.4 Critical Evaluation

2.4.i The Simplicity of Attachment Theory
Attachment theory has been criticised for being overly simplistic because it has not paid attention to the multiple factors that contribute to a relationship, (e.g. humour and intimacy), nor has it paid attention to the influence of the child's development on the attachment relationship (Dunn, 1993). Dunn (1993, p.31) has highlighted that social and cultural factors can influence attachment relationships and in reflecting on those from 'minority' cultures reported "the impact of growing awareness of minority status and of the different expectations and beliefs of a minority culture may be very great for some children, and the effects of their experiences at school may well be carried home." Rutter (1995) highlighted the multi-dimensional elements of relationships such as "connectedness, shared humour, balance of control, intimacy, and shared positive emotions" that need to be examined before we can clearly see patterns between relationships that an individual has and Rutter thought "it seems unlikely that these will be reducible to a single process involving attachment security or any other postulated quality." (Rutter, 1995, p.557).

Dunn (1993) has argued that attachment theorists have not paid enough attention to the impact of the child's development on the child-parent attachment relationship. As children grow older they may initiate conflict with their parents, for example a child may be fairly mild in temperament and then seem to change as they hit the 'terrible twos' (Dunn, 1993).

However, attachment theorists now acknowledge that many factors can lead to an insecure attachment including: "early parent-child separation; lack of fit between parent and child personality or temperament styles; a child with a difficult temperament who is hard to nurture; difficulties in the parent's own attachment histories and narcissistically damaged or abusive parents and the impact of loss and deprivation on the formation of the attachment" (Mackey, 2003, p.84). Berlin & Cassidy (1999, cited in Byng-Hall, 1999) argued that the following factors can affect infant-parent security: the parents relationship with the grandparents, the marital (partner) relationship between parents, social support from others and therapeutic...
relationships. According to Belsky (1999) none of these 'risk factors' are enough to make an attachment relationship insecure, but when combined can have a significant effect on the child-parent relationship. Belsky (1999) illustrated this point with an example: if a mother is depressed this would not necessarily affect the child-mother attachment relationship, however if the marital relationship is in conflict and there is no outside social support the child-mother attachment relationship is likely to be affected.

2.4.ii The Universality of Attachment Theory

Attachment theory appears to be valid in China, Africa, Japan and Israel (even in communal sleeping cultures), since "the majority of children develop secure attachments to their parents... the secure attachment strategy seems to appear from the most sensitive parenting... (and) secure attachment seems to increase the likelihood of better social competence in the future" (Van Ijzenoom & Sagi, 1999, p.730). However many cross-cultural studies have small sample sizes (Van Ijzenoom & Sagi, 1999) and since research has not been carried out in all cultures, attachment theory can not claim universality.

However, cross-cultural attachment research has been criticised for questioning "the periphery of their theory more than its core" (Rothbaum et al. 2000, p.1094). The assumptions that underlie the fundamental concepts in attachment theory are Western, individuation, exploration and autonomy are valued and in other cultures (such as Japan) these "qualities" are not held in such high regard (Rothbaum et al. 2000). Consequently child-rearing practices differ as does infant's behaviour. Adopting this Western theory in other cultures can have catastrophic consequences, for example, it can devalue non-Western child-rearing practices: "Americans' assumptions about attachment lead them to view Japanese care-giving practices as misguided, rather than as simply different, because Japanese practices inhibit infant exploration. Similarly, Japanese assumptions about attachment lead them to perceive U.S. relationships as being undermined by individualism and as weaker than, rather than merely different from their own relationships" (Rothbaum et al. 2000, p.1097). For Rothbaum et al., (2000) attachment theory needs to be context-specific, as do measures of attachment.
2.4.iii The Typological Approach to Attachment

The typological model of attachment has been questioned since little research has been done to test its validity (Rutter, 1995; Fraley & Waller 1998). Fraley & Waller's (1998, p.108) findings indicated "that the typological model traditionally favoured by attachment researchers does not capture the natural structure of attachment security. Rather they indicate that adult attachment organisation is ... a variable on which people differ in degree rather than kind." This is important because the way in which attachment is perceived (if it is seen in categorical or dimensional terms) affects the way research questions are posed, how research is conducted and how the aetiology of attachment patterns are understood (Fraley & Waller 1998). Researchers have questioned the assumption that attachment measured in adolescence and adulthood is the same concept as measured in infancy (Rutter, 1995).

However the use of categories or types is not fundamental to attachment theory (Bowlby, 1969) and measures developed more recently are often based on a dimensional rather than categorical approach. The Inventory of Parent and Peer Attachment (Armsden & Greenberg 1987), used in the current study is one such measure.

2.4.iv Using Attachment Theory Working with School Structures

An additional benefit of attachment theory is that it can be used in school settings. Connections between systems and attachment theory have been explored and used in combination for work with schools (Osborne, 1994). From this perspective, schools with good structures can act as a 'secure base', if students "experience consistent and caring behaviour from adults, and generally speaking are accepted by their peers" Barrett (1994, p.148). This may be extremely helpful if young people with school refusal have insecure attachments with their parents and therefore lack a secure base.

Therapists/ teacher consultants can go into schools and act as 'a secure base' for teachers to explore difficulties they may be having with students, such as school refusal (Barrett, 1994). This can be done on an individual or group basis (Barrett,
Barrett (1994, p.150) has stressed the importance of knowing about the culture of the whole system and the school structures before working with a subsystem, in particular a therapist should have some knowledge of the "belief system, hierarchical structure, lines of communication and boundaries". Clarification should be sought as to the teachers' view of the reason for the consultation before the process is started (Barrett, 1994).

Attachment theory can be used to guide group work with a school subsystem, providing "an opportunity for the group to reflect on its relationship to the whole institution and how its behaviour will have an effect on the whole school policy and belief system" (Barrett, 1994, p.159). This type of work aims to develop teachers' "professional confidence in self management and in their capacity to influence their environment to bring about change" (Barrett, 1994, p.159). This should have a positive impact on students and for example, help teachers to help school refusers return. However, in Tier 3 settings (such as those where this research was conducted), the young person may have been waiting a long time to see a clinical psychologist and in the mean time the school refusal may have become entrenched. In these circumstances, it may be more helpful to see the young person in the clinic and use attachment theory in working with the individual and family members in the first instance.

The strengths and weaknesses of attachment theory discussed above are outlined in table 3 on the next page.
<table>
<thead>
<tr>
<th>Concept/Issue</th>
<th>Weakness</th>
<th>Strength</th>
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</table>
| Internal Working Model (IWM) | • Too many definitions of the IWM.  
• The concept is too general and vague.  
• Do infants have the cognitive capacity for an IWM? (Dunn, 1993). | • Valuable tool which can be validated with further research. |
| Strange Situation | • Not appropriate for use with all cultures.  
• Assesses current relationship rather than earlier aspects of the relationship.  
• Problematic use of coding categories. (Rothbaum et al. 2000; Dunn, 1993). | • Is reliable and has predictive validity in the West (Solomon & George, 1999). |
<p>| Attachment narratives and stability of attachment | • Attachment narratives are strongly influenced by current experiences (Dunn, 1993). | • The concept of Attachment narratives is very useful in clinical work, particularly family therapy (Byng-Hall, 1999). |</p>
<table>
<thead>
<tr>
<th>Concept/Issue</th>
<th>Weakness</th>
<th>Strength</th>
</tr>
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</table>
| Attachments with siblings | • Relationships between siblings are multifaceted and influenced by external factors.  
• Siblings' relationships are affected by their own development (Dunn, 1993). | • Provide a useful framework for the clinician (Mackay, 2003). |
| Simplicity of attachment theory | • Attachment theory has been seen as too narrow as traditionally it focused on the mother-child dyad and the sensitivity of parenting (Rutter, 1995). | • Attachment theorists now acknowledge the important influence of other factors in and outside the relationship that can influence it (Mackey, 2003). |
| Universality of Attachment theory | • Attachment theory is based on Western assumptions.  
• It can not be applied to non-Western cultures  
• It has the potential to devalue non-Western child rearing practices. (Rothbaum et al. 2000). | • Attachment theory is valid with Western groups (if not generalised beyond this population).  
• Attachment theory provides the base for future culture specific research on relationships (Rothbaum et al. 2000). |
| Typological Approach to Attachment | • Classifying Attachment into types is misleading (Fraley & Waller, 1998). | • Not all attachment measures and research categorise attachment, this can be seen as a development within the attachment field. |
| An additional strength of Attachment Theory | | • Attachment theory can be used in school settings (Osborne, 1994). |
2.5. The Current Study

This section outlines research that is particularly pertinent to the current study; explains the rationale for the participants and measures adopted and makes the aims, objectives and hypotheses of the study explicit.

2.5.i Participants

The children who refused school interviewed in this study were all clients of a Tier 3 Child Adolescent Mental Health Service at the time of interviewing.

2.5.i.a Research Relating to Attachment Theory and Adolescence

During adolescence young people strive to develop autonomy and independence and research suggests that this is best achieved when there is a secure attachment between parent and child (Mackey, 2003). "In insecurely attached families, the differentiation process results in emotional cut-off or escalating power struggles with little evidence of accurate empathy" (Mackey, 2003, p.82). In these families difficult behaviours may be exhibited by teenagers, for example: "an ambivalently attached adolescent may use hostile, self-destructive behaviour as a way to both engage parental attention and to express anger and resistance" (Mackey, 2003, p.83). The parents in these families may lack empathy and be unable to respond sensitively to the needs of their child (Mackey, 2003).

Armsden, McCauley, Greenberg, Burke & Mitchell (1990) claimed that young people with an insecure attachment due to early parent-child interactions may be more likely to view the world as unpredictable and dangerous, "show less exploration, less competence and greater helplessness" (p.684), and as a result, have less positive experiences than those securely attached. Research by Armsden & Greenberg (1987) and Armsden (1986, cited in Armsden et al. 1990), using the same measure of attachment as adopted in the current study, found greater security of attachment correlated with higher self-esteem, and less vulnerability to depression and anxiety. Papini, Ruggmann & Anderson (1991) found that more securely attached 12 and 13 year olds reported less depression and social anxiety than those less securely attached. More recent research by McCarthy, Brack, Brak, Liu & Carlson (1998, cited in
Cretzmeyer, 2003) supports these findings, in that adolescents who were more attached to parents made a better adjustment to college, both academically and socially than those with lower parental attachment and family support.

2.5.i.b Previous Research Relating to Adolescence, Attachment and School Difficulties

There has been little research in this area. Bowlby (1973, 1998) argued that disturbed family dynamics would result in an anxious attachment which may present itself as school refusal (or an animal phobia or agoraphobia). Bowlby assumed that the child develops an anxious attachment to one or both parents as the child experiences the parents to be unapproachable and insensitive to her/his needs. Bowlby (1973, 1998) proposed four family interactional patterns associated with school refusal which are outlined in the table below.

Table 4: Bowlby's four family interactional patterns associated with school refusal

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>A</td>
<td>The mother (or sometimes father) experiences anxiety and difficulties with her/his own attachment figure and seeks fulfilment that would ideally come from her attachment figures (her parents or partner) from her child. The mother (or father) in this pattern keeps her child at home for company.</td>
</tr>
<tr>
<td>B</td>
<td>The child's anxiety about leaving home has been increased by life experiences such as death or a serious illness in a loved one. Consequently, the child is afraid that serious harm will befall mother (or sometimes father) whilst s/he is at school.</td>
</tr>
<tr>
<td>C</td>
<td>The child is afraid that something bad will happen to himself/herself if s/he does go to school. This may be connected to a threat used by parents to try and control their child. For example, the parents may have threatened to leave the child behind if behaviour does not improve.</td>
</tr>
<tr>
<td>D</td>
<td>The mother, fearing something awful will happen to the child in her absence, keeps her/him at home. It may be that the parent is unable to put experiences of ill health and misfortune of the child or another loved one in the past and believes that they are likely to recur.</td>
</tr>
</tbody>
</table>

Since there is little research in the adolescent age group, research with other age groups is also reported. Preschool and primary school age children who were securely attached to their mother have been shown to express less aggression and were less
likely to manifest behavioural problems than those with less secure attachments to their mothers (DeMulder, Denham, Schmidt & Mitchell 2000; Moss, Rousseau, Parent, St-Laurent & Saintogne 1998; Cohn, 1990). Moss & St-Laurent (2001) reported children classified as securely attached to their mothers at age six, scored more highly on measures of "communication, cognitive engagement, mastery and motivation" (p.863) at the age of eight than their peers who had been classified as insecurely attached to their mothers.

In the adolescent age range, Berg, Nichols & Pritchard (1969) investigated the relationship between school refusal and dependency on their mothers. Their sample included an acute group (those who had attended school without any difficulty for at least three years prior to onset), and a chronic group (those who did not meet the acute criteria). Berg et al. (1969) argued, "chronic cases were more attached to mother and father and probably less attached to a peer group" (p.135). This piece of research can be criticised for failing to include a control group and for using a measure of dependency rather than attachment.

Jacobsen & Hofmann (1997) investigated the relationship between attachment at age seven, later behaviour at school and academic achievement, when participants reached nine, 12 and 15 years. The researchers found that, on average, securely attached children achieved higher grades, had better attention, higher levels of participation and also a more secure sense of self. Drawing on Bowlby's (1987) theory, Jacobsen & Hofmann (1997) argued that if a child perceived his/her caregiver to be a secure base (in secure parent-child attachments), the child would have the confidence to wander off to explore and experiment with the world, safe in the knowledge that, should they become distressed, they could easily be re-united with their comforting parent. A child who has learnt that they cannot be sure that their parent will be there to comfort them if they feel threatened may be less willing to explore. Extended into childhood, the secure child may be more willing to engage in new school activities without being preoccupied about the location of their caregiver and thus pay more attention, participate more in class, and receive higher grades.

Jacobsen & Hofmann (1997) reported that young people rated as insecure in this study did not go on to develop behavioural problems and they were surprised that no link
between attachment and social interest at school was found. They questioned their choice of measures, arguing "outward friendliness may not be the best indicator of personal relationships" (Jacobsen & Hofmann, 1997, p.709). The authors called for further research "linking attachment to differences in close personal relationships during middle childhood and adolescence" (Jacobsen & Hofmann, 1997, p.709). They also requested that future research used measures specifically designed to assess attachment, as theirs did not (Jacobsen & Hofmann, 1997). It is precisely this request that forms the basis of the current research.

2.5.ii Measures Used in the Current research

From the literature above in the 'attachment with fathers' section, it can be hypothesised that the father-child relationship may be a better predictor of social relationships and school attendance or refusal than the mother-child relationship. Research by Banchero (2002) further supports this notion, since he found that the two most powerfully predictive variables of school drop-out were relationships with teachers and father. It was therefore important to use a measure that assessed attachment to fathers and this was one of the main reasons why the Inventory of Parent and Peer Attachment (Armsden & Greenberg 1987) was selected for this study. Another reason for choosing this measure was that it does not adopt the typological approach which has been so heavily criticised (see section above on strengths and weaknesses of attachment theory).

This study also used another measure (the Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997), merely to check that participants in the clinical group fitted the criteria for school refusal as defined by Heyne et al. (2002) and also to assess the utility of Heyne et al's criteria. The SDQ was chosen because it has good reliability and validity and it was more widely used in the services and easier to score than alternative behavioural screening measures.
2.5.iii Rationale, Aims and Objectives of the Current Research

To date, the aetiology of school refusal remains unclear. Research has typically focused on describing features of school refusal, factors associated with it, and approaches to treatment. Much of this research has been non-experimental, retrospective, used small sample sizes and lacked a control group. This research attempts to overcome these methodological weaknesses and consider the value of attachment theory in understanding the aetiology of school refusal. In particular, attachment to father is hypothesised to have a role in school refusal, given the role of the father-child relationships in adolescence (Steele, 2002).

The researcher believes that it would be helpful to consider whether early attachment experiences may act as a risk factor, with insecure attachments predisposing the individual to school refusal.

2.5.iv Hypotheses

1. School refusers will obtain lower scores than school attenders on a measure of perceived attachment to their mother.

2. School refusers will obtain lower scores than school attenders on a measure of perceived attachment to their father.

3. School refusers will obtain lower scores than school attenders on a measure of perceived attachment to their peers.
3. Method

3.1 The Design

A between groups design was adopted, comparing the attachment relationships to mothers, father and peers of school attenders with those of non-attenders.

3.2 Power Analysis

A priori power analysis was conducted using G*POWER (Erdfelder, Faul & Buchner, 1996). The calculation was made on the basis of using a t-test with the aim of achieving a medium effect size. Given that power was set at .70 and the effect size was set at 0.5, the recommended sample size was 78.

3.3 Participants

Seventy-nine young people took part in this study. Sixteen of these were recruited from two Child and Adolescent Mental Health Services (CAMHS). Clinicians in these teams used Heyne, et al.'s (2002) criteria (listed in the Introduction) to identify school refusers aged 11 to 15 on their case-loads who had missed at least half of the last school term.

Sixty-three participants were school attenders. Initially there were 65 school attenders but two had to be excluded as during the interview it became clear that they had a history of refusing, and this was later confirmed by staff at the school. School attenders were the same age as the refusers, and were students at secondary school. Attendees were recruited from five schools, ranging from grammar to community college. This aimed to ensure a mix of educational and social class backgrounds within the sample. Male and female attenders and refusers were interviewed. The following groups were excluded: those with a learning disability, those that did not speak English and those who had had problems with the Youth Justice system.
All participants and their parents were given information sheets to read and a consent form to sign (see Appendix 4 for participant information sheets and Appendix 5 for consent forms) before they were interviewed.

3.4 Measures

3.4.i Demographics
Demographic information was obtained from each participant. This included age, sex, family constitution, educational background of the parents and the child and employment status of the parents. Demographic data are recorded in the results section. In addition, each participant was asked some open-ended questions about their experience of school (see Appendix 6).

3.4.ii The Inventory of Parent and Peer Attachment
According to Paterson, Field & Pryor (1994), the Inventory of Parent and Peer Attachment (IPPA) was designed by Greenberg, Siegel & Leitch (1983) and modified by Armsden & Greenberg (1987) and Armsden (1986, cited in Paterson et al., 1994). Armsden et al. (1990) reported that Bowlby's theory (1962/1982 cited in Armsden et al. 1990) and the work of Bretherton & Waters (1985, cited in Armsden et al. 1990) underpin the IPPA. Strength of attachment was inferred by the probability of an individual using that relationship for support in times of difficulty (Papini, Roggman & Anderson, 1991). This tool attempted to measure the degree of psychological security provided for the individual by their mother, father and peers (Papini et al., 1991). Each of the three scales was made up of three sub-scales: "the degree of mutual trust, quality of communication and the extent of anger and alienation" (Armsden et al., 1990, p.687). A copy of the IPPA can be found in Appendix 7.

Although the IPPA was a self-report measure, in this study the questions were read to participants by the researcher. The questions were 25 descriptive statements about cognitive/affective and behavioural aspects of the individual's relationship with
mother, father and peers (Blain, Thompson & Whiffen, 1993; Armsden & Greenberg, 1987). Responses were in the form of a five-point Likert-style scale from *never* or *almost never* true (0), to *always* or *almost always* true (5). Three attachment scores (one for mother, another for father and a third for peers) were calculated by summing responses for items of the scale, some of which are reversed scored (Paterson, Pryor & Field, 1995). Although the development sample consisted of 179 individuals aged between 16 to 20 years of age, the measure has been used with those as young as 12 (Armsden & Greenberg, 2003).

The test-retest reliability for an earlier version of this scale that only had one parent scale (i.e. mother and father combined versus peers) was assessed over a three-week period and was found to be 0.93 for parent attachment and 0.86 for peer attachment (Armsden & Greenberg, 1987). The measure seems to have content validity, construct validity and convergent validity (Armsden & Greenberg, 1987, 2003).

### 3.4.iii The Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997) is a behavioural screening measure that consists of five subscales (Mathai, Anderson & Bourne, 2002). Each subscale has five questions each, thus there are 25 questions in total. The five subscales assess: conduct problems, hyperactivity, emotional symptoms, peer problems and pro-social behaviour (Goodman & Scott, 1999). A copy of the SDQ can be found in Appendix 8.

The SDQ for 11-15 year olds was used in this study. Parents completed the parent version in the clinical sample (school refusers). The researcher read the questions of the self-report version to all participants and recorded their responses during their interview. The teacher's version was not used in this study. Questions were in the form of statements that may or may not describe the young person. Parent and child reported whether each statement is *not true* (scoring 0), *somewhat true* (1), or *certainly true* (2). This yields scores out of ten for each subscale and a total difficulties score out of forty can be obtained by summing all responses except those on the pro-social subscale (Mathai et al., 2002).
Goodman (2001) reported cross-informant reliability of 0.34, a test-retest reliability over four to six months as 0.62, and, in his study, a cronbach alpha of 0.73 indicating moderate internal consistency.

With regard to validity, Goodman (1997, cited in Mathai et al., 2002) has shown that the SDQ correlates highly with the well-established Rutter behavioural screening questionnaire. Mathai et al. (2002) stress the advantages of the SDQ over the Rutter scales, namely that the SDQ is a better measure of attention difficulties, friendships and sociable behaviour. The SDQ was able to distinguish between low and high-psychiatric-risk as well as the Child Behaviour Checklist (CBCL), another screening tool (Goodman & Scott, 1999). Furthermore the SDQ identifies inattention and hyperactivity more sensitively than the CBCL does (Goodman & Scott, 1999).

Goodman, Ford, Simmons, Gatward & Howart (2000) found that within the community, using the child, parent and teacher versions of the SDQ in combination enabled psychiatric diagnoses to be detected "with a specificity of 94.6% (95% CI 94.1-95.1%) and a sensitivity of 63.3% (59.7-66.9%)" (p.534). However, Goodman et al. (2000) also reported that in cases where single rather than multi-informant SDQs were used, the sensitivity was greatly reduced.

3.5 Procedure

The researcher informed head teachers and clinicians about the study. Service users were told about the study by their clinicians. School attenders and their parents were told about the study by form tutors and head teachers at their school.

Clinicians let the researcher know about school refusers who fitted the criteria and were interested in taking part in the study. The researcher then sent the young person and their parent/guardian a copy of the information sheet (see Appendix 4) and consent form (see Appendix 5). This was followed up with a phone call in which the participant and their guardian could ask questions about the research and arrange a date and time to be interviewed. Following this, the researcher then met the young
person and their guardian in their CAMHS. Having received a signed consent form, the young person was interviewed alone for approximately half an hour. During this time, the guardian completed the parent version of the SDQ (Goodman, 1997) in the waiting room.

School attenders were interviewed on an individual basis once the researcher had received their signed consent form. The interview consisted of a couple of initial demographic questions, the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987), the child version of the SDQ (Goodman, 1997) and some general open-ended questions about family and school life. A copy of the interview schedule can be found in Appendix 6. The guardians of school attenders did not complete the parents version of the SDQ as it was thought that this was not essential and it could deter parents from consenting to participate in the research. The main reason for this is that they may have worried that the research was trying to identify 'problems' in their children.

Interview records were anonymised and allocated a number so that they could be recalled and discounted from the study if, at a later date a participant withdrew their consent. Records were then kept in a locked cupboard. A database was designed and created to analyse the quantitative data using the Statistical Package for the Social Sciences – version 11 (SPSS 11).

3.6 Ethical Approval

The project was reviewed and approved by the University of Surrey Ethics Committee and the West Kent NHS and Social Care Trust Ethics Committee and Research and Development Committee (See Appendices 1, 2 and 3).
3.7 Data Analysis

The data was analysed using SPSS - version 11. Independent t-tests were used to compare the attachment relationships of school attenders to their main care-givers and peers with school refusers and their main caregivers and peers. For both groups of children, attachment to mother father and peers were assessed. It was possible to use independent t-tests as the assumptions of parametric tests were satisfied for all variables, with the exception of trust for peers and communication with peers. The dependent variables (attachment) produce interval level data and "the population from which the sample was drawn was normally distributed" (Coolican, 1990, p.196). Finally, there was no significant difference between the variance of the school attenders and school refusers, i.e. there was homogeneity of variance (Coolican, 1990).

However, the 'trust of peers' variable, the 'communication with peers' variable, and the SDQ variables were significantly different from the normal distribution, thus conditions for parametric tests were not met. Non-parametric tests (Mann Whitney) were used to compare the school refusers' and school attenders' degree of trust and communication with peers. Mann Whitney tests were also used to compare the scores of the child version SDQ for school refusers and school attenders. A Wilcoxon signed rank test was used within the clinical group, to compare child and parent scores on the SDQ.
4. Results

4.1 Demographics

There were 79 participants in the study. The 16 participants in the experimental group were school refusers being seen by mental health professionals in CAMHS services. There were 63 school attenders in the control group.

4.1.i Age and Sex

All participants were of secondary school age, ranging from 11 to 15 years. There were 28 males (44%) in the control group and nine males (56%) in the experimental group. There were 35 females (56%) in the control group and seven females (44%) in the experimental group.

<table>
<thead>
<tr>
<th>Sex</th>
<th>SR n (actual number)</th>
<th>SR proportion</th>
<th>SA n</th>
<th>SA proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>7</td>
<td>44%</td>
<td>35</td>
<td>56%</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>56%</td>
<td>28</td>
<td>44%</td>
</tr>
</tbody>
</table>

The overall mean age of the sample was 13.18 and the standard deviation (s.d.) was 1.035, the mean and standard deviations can be seen in table 6 below.

<table>
<thead>
<tr>
<th></th>
<th>SR mean age</th>
<th>SR standard deviation</th>
<th>SA mean age</th>
<th>SA standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>13.19</td>
<td>1.56</td>
<td>13.17</td>
<td>0.87</td>
</tr>
</tbody>
</table>

A Mann Whitney test was run to compare the mean ages across groups. A Mann Whitney test was used because the data was significantly different from the normal
distribution and it could not be transformed. Table 7 below shows that there was no significant difference in age between the two groups, since \( p > 0.05 \).

Table 7: Results of a Mann Whitney test comparing ages across the school attending and school refusing group

<table>
<thead>
<tr>
<th>SR Mean Rank</th>
<th>Z Score</th>
<th>Sig.</th>
<th>Is it significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.34</td>
<td>-0.072</td>
<td>0.943</td>
<td>No</td>
</tr>
<tr>
<td>39.91</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.1.ii Ethnicity

Table 8 below shows that all participants were White British with the exception of one Black British person in the control group.

Table 8: Ethnicity of the school refusing group and school attending group

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>SR n</th>
<th>SR proportion</th>
<th>SA n</th>
<th>SA proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>16</td>
<td>100%</td>
<td>62</td>
<td>98.4%</td>
</tr>
<tr>
<td>Black British</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

4.1.iii Family Background

Tables 9 and 10 show the family make-up of each group, showing greater information for the children from single parent families. Eleven of the sixteen school refusers had parents that were still together (70%). Of the school refusers' families whose parents had separated, four (25%) did not have their father at home, 1 (5%) had neither parent living with them and 2 (13%) lived with one parent and that parent's partner. Five (31%) of school refusers whose parents had separated had at least one sibling at home.

In the control sample, 47 (72%) participants lived with their parents who were still together. Of the school attenders' families whose parents had separated, fourteen (22%) did not have their father at home, two (3%) did not have their mother at home,
all had one parent at home and eight (13%) lived with one parent and that parent's partner. Twelve (18%) of school attenders whose parents had separated had at least one sibling at home. It seems as though there was similarity between the conditions with regard to family make up.

Table 9: General family make-up of the school refusing group and the school attending group

<table>
<thead>
<tr>
<th></th>
<th>SR n</th>
<th>SR proportion</th>
<th>SA n</th>
<th>SA proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents living with child</td>
<td>11</td>
<td>70%</td>
<td>47</td>
<td>72%</td>
</tr>
<tr>
<td>Sibling(s) at home</td>
<td>13</td>
<td>81%</td>
<td>55</td>
<td>85%</td>
</tr>
</tbody>
</table>

Table 10: The numbers and proportions of each group with single parent/reconstituted families

<table>
<thead>
<tr>
<th></th>
<th>SR n</th>
<th>SR proportion</th>
<th>SA n</th>
<th>SA proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father not at home with child</td>
<td>4</td>
<td>25%</td>
<td>14</td>
<td>22%</td>
</tr>
<tr>
<td>Mother not at home with child</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>3%</td>
</tr>
<tr>
<td>Niether parent living with child</td>
<td>1</td>
<td>5%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Parent's partner living with parent and child</td>
<td>2</td>
<td>13%</td>
<td>8</td>
<td>13%</td>
</tr>
<tr>
<td>Sibling(s) at home</td>
<td>5</td>
<td>31%</td>
<td>12</td>
<td>18%</td>
</tr>
</tbody>
</table>
Most young people were unsure how old their parents were when they left school. It was difficult to classify jobs according to social class as the only available evidence was the young person’s self report and so the reliability is questionable. Employment status was therefore classified as 'paid employment', 'unemployed', 'at home' (through choice) and 'do not know', as shown in table 11 below and a complete list of reported occupations can be found in Appendix 9. Of the school refusers, 13 (81%) reported they had mothers who worked and 13 (81%) had fathers who worked. One (6%) mother and one father (6%) were unemployed. Two school refusers (13%) reported that their mother chose to stay at home; no fathers in this group chose to stay at home. All school refusers reported they knew the employment status of their mother and two school refusers (13%) reported they were not sure of the employment status of their father.

Forty-nine (78%) school attenders reported that their mothers were in paid employment. Fifty-six (89%) school attenders reported that their fathers were in paid employment. None of the school attenders reported that their mother was unemployed, three (5%) reported that their fathers were unemployed. Fourteen (22%) school attenders reported that their mother chose to stay at home, one (2%) reported that their father chose to stay at home. All school attenders reported that they knew the employment status of their mother, and four (6%) said that they did not know the employment status of their father. The employment status of the single parent families is shown in table 12.

<table>
<thead>
<tr>
<th></th>
<th>School Refusers</th>
<th>School Attenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>81%</td>
<td>78%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>At Home</td>
<td>13%</td>
<td>22%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>Totals</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 11: Employment status of participants' parents in the school refusing and school attending group
Table 12: Employment status of the single parent families in the school refusing and the school attending group

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>SR n</th>
<th>SR proportion</th>
<th>SA n</th>
<th>SA proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother employed</td>
<td>3</td>
<td>18%</td>
<td>14</td>
<td>22%</td>
</tr>
<tr>
<td>Father employed</td>
<td>2</td>
<td>13%</td>
<td>13</td>
<td>20%</td>
</tr>
<tr>
<td>Mother unemployed</td>
<td>1</td>
<td>6%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Father unemployed</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Mother 'at home'</td>
<td>1</td>
<td>6%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Father 'at home'</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don't know mother's employment Status</td>
<td>1</td>
<td>6%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Don't know father's employment status</td>
<td>3</td>
<td>18%</td>
<td>3</td>
<td>5%</td>
</tr>
<tr>
<td>Step-parent/guardian employed</td>
<td>2</td>
<td>13%</td>
<td>7</td>
<td>11%</td>
</tr>
<tr>
<td>Step-parent/guardian unemployed</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Step-parent/guardian at home</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Don't know step-parent/guardian's Employment status</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
4.2 Open-ended Answers

All the school refusers reported that they had missed a substantial amount of school in the past term. Only two of the attenders reported this and they were excluded from the sample. The same pattern was observed in response to the question asking whether the participant had ever had difficulty attending school. In response to the question asking what the young person liked about school, 43% of the school refusers said "nothing". The second most common response was to cite particular subject(s) (31% of school refusers reported this). School attenders most frequently reported that they liked the social element of school, seeing their friends (80%), and certain lessons (20%). Many cited more than one particular like.

In the school refusing group, the most common response when asked what they disliked about school was "don't know" (23%). Others said: "everything", "too long a day", "bullies", "nothing", "pressure" and "too many people". School attenders most frequently reported that they disliked particular subject(s) (18%), followed by particular teachers (16%), and homework (13%). Other responses by the school attenders included: bullies, that the school day was too long, sport, and some said nothing.

Of the school refusers, 40% reported having had extra help for subject(s) in the past. Of the school attenders, 32% reported that they had received extra help for certain subject(s) in the past. In both groups, the most frequently cited subject for which they received extra help was literacy. The range of grades reported varied greatly and 30% of school refusers said that they did not know how well they had done at school. The school attenders also gave a wide range of responses when asked about the grades they typically got at school. The majority (60%) reported grades A-C but some reported D and E grades and others said that they did not know. It must be stressed that this information is all based on self-report by the young person. Given that this did not relate to the main research question, other evidence (such as teacher report) was not sought and thus it could be argued that this data is of questionable reliability.
4.3 Quantitative Analysis

4.3.i Normality of Data

Analysis showed that two variables, namely 'Alienation from fathers' and 'Alienation from peers' had significantly different variances and therefore results from calculations which did not assume equal variance (Levene's test) were used.

The attachment to mother variables, the attachment to father variables, with the exception of 'Trust with father', and some of the attachment to peers variables, were not significantly different from the normal distribution. A log transformation was used to make 'Trust for father' more normally distributed. This transformed data was then used in a t-test. Two of the attachment to peer variables, 'trust of peers' and 'communication with peers' were significantly different from the normal distribution and could not be transformed so Mann Whitney tests were adopted.

All SDQ variables, except the SDQ Total were significantly different from the normal distribution. Attempts were made to transform the other variables data so that it was not significantly different from the normal distribution but, none of the approaches were able to achieve this. Consequently, non-parametric (Mann Whitney and Wilcoxon) tests were adopted. Results were obtained through the use of SPSS version 11.

Observed power and effect size were calculated through the General Linear Model (ANOVA) function within SPSS. Whilst it is recognised that this may be seen as incompatible with the choice of non-parametric tests, it was considered acceptable to do this since parametric tests (ANOVA and t-tests) revealed the same findings as the non-parametric tests reported here.
4.4 Exploratory analysis of Strengths and Difficulties Questionnaire Profiles

As there were six main tests, a Bonferroni Correction was used and the significance level was set at 0.008512 (Simple Interactive Statistical Analysis, 2004).

4.4.i Total SDQ Scores
A t-test was run to compare the difference in mean total SDQ scores between the two conditions, as this data was not significantly differently distributed from the normal distribution. Analysis showed that the two conditions had significantly different variances and, therefore, results from calculations which did not assume equal variance (Levene's test) were used. School refusers scored more highly than attenders on the SDQ overall (total) and this difference was statistically significant (t = 4.725, df = 27.320. p = <0.001).

Table 13 shows results of Mann Whitney analysis which was carried out on the total SDQ scores (despite the fact that the distribution of data was not significantly different from the normal distribution), for the sake of completeness, and comparison with SDQ subscale scores.

4.4.ii Emotion Subscale
There was a statistically significant difference between groups on the emotional subscale, a small to medium effect size was observed, and observed power was at the maximum level.

4.4.iii Conduct Subscale
Table 13 suggests a significant difference between the two groups on this subscale. The effect size was small but the observed power was high.
(However, once the two 'truantish' participants were excluded from the analysis, the difference was no longer statistically significant – see the 'Discussion' section).

4.4.iv Peer Subscale

Table 13 suggests a significant difference between the conditions on this scale. The effect size was small but observed power was high.

4.4.v Pro-social Subscale

There was no significant difference between the conditions on this subscale. The effect size and observed power were very low.

4.4.vi Hyperactivity Subscale

There was no significant difference between the conditions on this subscale. Again, effect size and observed power were very low.
Table 13: The means, standard deviations, Mann Whitney results, effect size and observed power on the SDQ score differences across conditions

<table>
<thead>
<tr>
<th></th>
<th>SR Mean (Standard deviation)</th>
<th>SR: Mean Rank</th>
<th>Z score</th>
<th>Sig.</th>
<th>Is it significant, Yes or No?</th>
<th>Partial Eta Squared (η²)</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child SDQ Total Score</td>
<td>40.87 (4.35)</td>
<td>62.63</td>
<td>-4.430</td>
<td>&lt;.001</td>
<td>Yes</td>
<td>.188</td>
<td>.986</td>
</tr>
<tr>
<td>Child SDQ Prosocial Score</td>
<td>12.94 (1.57)</td>
<td>38.19</td>
<td>-3.62</td>
<td>.718</td>
<td>No</td>
<td>.001</td>
<td>.060</td>
</tr>
<tr>
<td>Child SDQ Hyperactivity Score</td>
<td>10.44 (1.63)</td>
<td>45.81</td>
<td>-1.162</td>
<td>.245</td>
<td>No</td>
<td>.001</td>
<td>.060</td>
</tr>
<tr>
<td>Child SDQ Emotional Score</td>
<td>11.06 (2.26)</td>
<td>62.75</td>
<td>-4.516</td>
<td>&lt;.001</td>
<td>Yes</td>
<td>.303</td>
<td>1.000</td>
</tr>
<tr>
<td>Child SDQ Conduct Score</td>
<td>8.81 (1.68)</td>
<td>54.28</td>
<td>-2.891</td>
<td>.004</td>
<td>Yes</td>
<td>.112</td>
<td>.868</td>
</tr>
<tr>
<td>Child SDQ Peer Score</td>
<td>10.56 (1.41)</td>
<td>54.81</td>
<td>-3.014</td>
<td>.003</td>
<td>Yes</td>
<td>.111</td>
<td>.865</td>
</tr>
<tr>
<td></td>
<td>9.45 (1.28)</td>
<td>36.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.4.vii Analysis of Parent and Child Strengths and Difficulties Questionnaire Profiles in the Clinical Sample

An additional analysis was run to compare the results on the SDQ of the school refusing children with their parents. A Wilcoxon signed ranks test was used as the data in each group were related, but were significantly different from the normal distribution. As there were six main tests, a Bonferroni Correction was used and the significance level was set at 0.008512 (Simple Interactive Statistical Analysis, 2004). Table 14 below shows that there were no significant differences between the parent-rated and child-rated scores on each of the subscales, and the total SDQ scores.
Table 14: Scores on the SDQ of school refusing children compared with their parents

<table>
<thead>
<tr>
<th></th>
<th>SR Mean (S.d.)</th>
<th>Mean Positive Rank</th>
<th>Z score</th>
<th>Sig.</th>
<th>Is it significant, Y/ N?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent of SR Mean (S.d.)</td>
<td></td>
<td>Mean Negative rank</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total SDQ</td>
<td>40.88 (4.35)</td>
<td>8.14</td>
<td>-1.172</td>
<td>.864</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>40.80 (3.59)</td>
<td>7.88</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pro-social</td>
<td>12.94 (1.57)</td>
<td>3.00</td>
<td>-1.90</td>
<td>.057</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>12.13 (1.41)</td>
<td>6.57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>10.44 (1.63)</td>
<td>6.33</td>
<td>-1.59</td>
<td>.111</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>9.94 (2.43)</td>
<td>6.56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>11.06 (2.26)</td>
<td>6.40</td>
<td>-.092</td>
<td>.927</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>11.19 (2.17)</td>
<td>5.67</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct</td>
<td>8.81 (1.68)</td>
<td>6.00</td>
<td>-.262</td>
<td>.794</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>8.88 (2.30)</td>
<td>5.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peer</td>
<td>10.56 (1.41)</td>
<td>5.80</td>
<td>-.780</td>
<td>.435</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>10.73 (1.39)</td>
<td>4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.4.viii Categorisation Data of the SDQ

The scores obtained on the SDQ were compared across groups. Table 15 below shows how many participants in each group fell in the 'low', 'medium' and 'high' ranges on each subscale. The proportion of each group scoring in each range, for each subscale, is also shown. For example, whilst only 38% of school refusers fell in the 'low' range on the subscale of emotional difficulties, 85% of school attenders fell in this low range. Interestingly, on the peer problems subscale, 0% of school refusers fell in the low range and 38% fell in the high range compared with 19% of school attenders in the low range and a further 19% in the high range.

Table 15: The number and proportion of each group scoring in the low, medium and high ranges on the SDQ

<table>
<thead>
<tr>
<th></th>
<th>LOW NEED</th>
<th></th>
<th>SOME NEED</th>
<th></th>
<th>HIGH NEED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SR</td>
<td>SA</td>
<td>SR</td>
<td>SA</td>
<td>SR</td>
<td>SA</td>
</tr>
<tr>
<td>Total Difficulties</td>
<td>10</td>
<td>56</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(62%)</td>
<td>(89%)</td>
<td>(19%)</td>
<td>(10%)</td>
<td>(19%)</td>
<td>(1%)</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>8</td>
<td>51</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>(50%)</td>
<td>(81%)</td>
<td>(19%)</td>
<td>(8%)</td>
<td>(31%)</td>
<td>(11%)</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>8</td>
<td>38</td>
<td>6</td>
<td>19</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(50%)</td>
<td>(60%)</td>
<td>(38%)</td>
<td>(30%)</td>
<td>(12%)</td>
<td>(10%)</td>
</tr>
<tr>
<td>Emotional</td>
<td>6</td>
<td>54</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(38%)</td>
<td>(85%)</td>
<td>(25%)</td>
<td>(5%)</td>
<td>(38%)</td>
<td>(10%)</td>
</tr>
<tr>
<td>Peer Problems</td>
<td>0</td>
<td>12</td>
<td>10</td>
<td>39</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>(19%)</td>
<td>(62%)</td>
<td>(62%)</td>
<td>(38%)</td>
<td>(19%)</td>
</tr>
<tr>
<td>Pro-social</td>
<td>15</td>
<td>59</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(94%)</td>
<td>(94%)</td>
<td>(6%)</td>
<td>(3%)</td>
<td>(0%)</td>
<td>(3%)</td>
</tr>
</tbody>
</table>
4.5 Inventory of Peer and Parental Attachment

T-tests were performed to identify the effect of the independent variable (school refusal) on the dependent variables:

1. Attachment to mother
2. Attachment to father
3. Attachment to peer

As there were three main tests, a Bonferroni Correction was used and the significance level was set at 0.0167 (Simple Interactive Statistical Analysis, 2004).

4.6. Hypothesis 1: School Refusers Will Obtain Lower Scores Than School Attenders On A Measure of Perceived Attachment To Their Mother

4.6.i Maternal Attachment

Attachment to mother was assessed in both groups using the Inventory of Parent and Peer Attachment. The attachment to mother scale consists of three subscales (as is the case with the attachment to father scale and the attachment to peer scale), these are: degree of mutual trust, quality of communication, and extent of anger and alienation. T-tests were performed to compare scores on each of these three subscales across groups, as well as total score of attachment.

4.6.ii Overall Attachment to Mother

Table 16 shows that no significant difference was observed between groups, effect size and observed power were also low.
4.6.iii Trust (Felt Security) That Mother Understands and Respects the Young Person's Needs

Table 16 shows that the difference between the two groups was not statistically significant at the 0.017 level. However, the results suggest that school refusers were less able to trust the "accessibility and responsiveness of" their mother (Armsden & Greenberg, 1987, p. 431) than school attenders. Effect size and observed power were low.

4.6.iv Quality of Communication with Mother

Table 16 shows that there was no significant difference in the quality of communication between the young person and their mother, as judged by the young person, in both conditions. The effect size and observed power were low.

4.6.v Degree of Alienation from Mother

Table 16 shows that there was no statistically significant difference between the two groups, in the extent to which young people felt anger towards and emotional detachment from their mother {which can be seen as "responses to actual or threatened disruption of an insecure attachment bond" (Armsden & Greenberg, 1987, p.433)}. There was no effect size and low observed power.
Table 16: Results of means, standard deviations t-tests results, effect size and observed power in attachment to mother between conditions

<table>
<thead>
<tr>
<th></th>
<th>SR:</th>
<th>t</th>
<th>df</th>
<th>P</th>
<th>Is it significant, Y/N?</th>
<th>Partial $\eta^2$</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (Sd)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Attachment to Mother</td>
<td>SA:M (S.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SR: 77.56 (5.21)</td>
<td>-0.926</td>
<td>77</td>
<td>0.36</td>
<td>N</td>
<td>0.011</td>
<td>0.150</td>
</tr>
<tr>
<td></td>
<td>SA: 78.70 (4.15)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust for Mother</td>
<td>SA: 39.90 (3.30)</td>
<td>-2.16</td>
<td>77</td>
<td>0.034</td>
<td>N</td>
<td>0.057</td>
<td>0.57</td>
</tr>
<tr>
<td>Communication with Mother</td>
<td>SA: 20.30 (3.00)</td>
<td>0.89</td>
<td>77</td>
<td>0.376</td>
<td>N</td>
<td>0.10</td>
<td>0.142</td>
</tr>
<tr>
<td>Alienation from Mother</td>
<td>SA: 23.50 (3.48)</td>
<td>-0.011</td>
<td>77</td>
<td>0.991</td>
<td>N</td>
<td>0.00</td>
<td>0.50</td>
</tr>
</tbody>
</table>

220
4.7 Hypothesis 2: School Refusers Will Obtain Lower Scores Than School Attenders On A Measure Of Perceived Attachment To Their Father

4.7.i Overall Attachment to Father
Table 17 shows that there was no significant difference between the two groups with regard to overall attachment scores to father. Effect size and observed power were low.

4.7.ii Degree of Mutual Trust with Father
Table 17 shows that there was a statistically significant difference between the two groups with regard to the degree of mutual trust young people experienced with their father. Whilst the effect size was small, observed power was high.

4.7.iii Quality of Communication with Father
Table 17 suggests that there was a statistically significant difference in the quality of communication between the young person and their father, as judged by the young person, in both conditions. There was a small effect size but high observed power.

4.7.iv Degree of Alienation from Father
Table 17 shows that there was no significant difference in the extent to which young people felt anger towards and emotional detachment from their father across conditions. Effect size and observed power was low.
Table 17: Results of means, standard deviations, t-tests results, effect size and observed power in attachment to father between conditions

<table>
<thead>
<tr>
<th></th>
<th>SR: M (S.d.)</th>
<th>t</th>
<th>df</th>
<th>P</th>
<th>Is it significant, Y/N?</th>
<th>Partial $\eta^2$</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Attachment to Father</strong></td>
<td>SA: M (S.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR: 78.6 (4.22)</td>
<td>-0.79</td>
<td>74</td>
<td>.430</td>
<td>N</td>
<td>.008</td>
<td>.123</td>
<td></td>
</tr>
<tr>
<td>SA: 79.50 (3.91)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trust for Father (transformed)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR: 1169.73 (383.349)</td>
<td>-3.43</td>
<td>74</td>
<td>&lt;0.001</td>
<td>Y</td>
<td>.138</td>
<td>.924</td>
<td></td>
</tr>
<tr>
<td>SA: 1505.16 (327.58)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Communication with Father</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR: 24.47 (3.52)</td>
<td>3.534</td>
<td>74</td>
<td>0.01</td>
<td>Y</td>
<td>.144</td>
<td>.937</td>
<td></td>
</tr>
<tr>
<td>SA: 21.10 (3.25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alienation from Father</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR: 21.60 (4.03)</td>
<td>-0.661</td>
<td>74</td>
<td>0.511</td>
<td>N</td>
<td>.006</td>
<td>.100</td>
<td></td>
</tr>
<tr>
<td>SA: 22.10 (2.16)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.8. Hypothesis 3: School Refusers Will Obtain Lower Scores Than School Attenders On A Measure Of Perceived Attachment To Their Peers

4.8.i Overall Attachment to Peers
Table 18 shows that there was a statistically significant difference between the two groups. There was a small effect size but observed power was fairly high.

4.8.ii Trust (Felt Security) That Peers Understand and Respect the Young Person's Needs
Table 18 shows that the observed difference in degree of trust of peers was not statistically significant at the 0.0167 level. There was a small effect size but observed power was fairly high.

4.8.iii Quality of Communication with Peers
Table 18 shows that there was not a significant difference in the quality of communication between the young person and their peers between conditions. Effect size and observed power were low.

4.8.iv Degree of Alienation from Peers
Table 18 shows that there was a statistically significant difference in the extent to which young people felt anger towards and emotional detachment from their peers across conditions. Whilst effect size was small, observed power was high.
Table 18: Results of mean, standard deviation t-tests, effect size and observed power in attachment to peers between conditions

<table>
<thead>
<tr>
<th>SR: M (S.d.)</th>
<th>t</th>
<th>df</th>
<th>P</th>
<th>Is it significant, Y/N?</th>
<th>Partial $\eta^2$</th>
<th>Observed Power</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA: M (S.d.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Attachment to Peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR: 94.88 (13.89)</td>
<td>-2.62</td>
<td>77</td>
<td>.011</td>
<td>Y</td>
<td>.082</td>
<td>.735</td>
</tr>
<tr>
<td>SA: 103.65 (11.44)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust for Peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR: 41.25 (6.34)</td>
<td>Z score -1.86</td>
<td></td>
<td>.062</td>
<td>N</td>
<td>.063</td>
<td>.616</td>
</tr>
<tr>
<td>Mean rank 30.47</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA: 44.32 (4.34)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean rank 42.42</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication with Peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SR: 29.25 (6.70)</td>
<td>Z score -1.49</td>
<td></td>
<td>.136</td>
<td>N</td>
<td>.031</td>
<td>.342</td>
</tr>
<tr>
<td>Mean rank 32.38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA: 31.79 (5.53)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean rank 41.94</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alienation from Peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SA: 17.63 (5.06)</td>
<td>2.862</td>
<td>77</td>
<td>.005</td>
<td>Y</td>
<td>.096</td>
<td>.807</td>
</tr>
<tr>
<td>SR: 14.46 (3.63)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.9. Summary of Results

Results indicated that there was a significant difference in the degree to which school refusers and school attenders trusted their fathers, with the latter group reporting higher levels of trust. Interestingly the results indicated that school refusers communicated more with their fathers than school attenders did. Results also indicated that there was a significant difference in scores obtained on a measure of alienation from and attachment to peers. School refusers obtained higher scores on a measure of alienation and a lower score on a measure of overall attachment.

There was a significant difference between school refusers and school attenders in the total scores on the SDQ, with school refusers gaining significantly higher total scores than school attenders. School refusers also obtained statistically significantly higher scores on the Emotion subscale of the SDQ than the school attenders. A greater proportion of school refusers, compared to school attenders, fell into the high range on peer problems. There were no significant differences between parent and child rated SDQ scores within the clinical sample.
5. Discussion

5.1 Discussion of Main Findings

This study aimed to examine whether school refusers’ attachment relationships to parents and peers were different from the school attenders’ attachment relationships to parents and peers. With regard to the three main hypotheses, only the third, "that school refusers will obtain lower scores than school attenders on a measure of perceived attachment to their peers" was supported statistically. Table 19 below summarises these findings.

Table 19: Significant and non-significant results

<table>
<thead>
<tr>
<th>Scale</th>
<th>Significant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall attachment to mother</td>
<td>No</td>
</tr>
<tr>
<td>Trust for mother</td>
<td>No</td>
</tr>
<tr>
<td>Communication with mother</td>
<td>No</td>
</tr>
<tr>
<td>Alienation from mother</td>
<td>No</td>
</tr>
<tr>
<td>Overall attachment to father</td>
<td>No</td>
</tr>
<tr>
<td>Trust for father</td>
<td>Yes</td>
</tr>
<tr>
<td>Communication with father</td>
<td>Yes</td>
</tr>
<tr>
<td>Alienation from father</td>
<td>No</td>
</tr>
<tr>
<td>Overall attachment to peers</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust for peers</td>
<td>No</td>
</tr>
<tr>
<td>Communication with peers</td>
<td>No</td>
</tr>
<tr>
<td>Alienation from peers</td>
<td>Yes</td>
</tr>
</tbody>
</table>

5.2. What is Surprising About These Results?

It was hypothesised that school refusers would obtain lower scores than school attenders on a measure of perceived attachment to their mother and father and yet this was not found to be the case. These hypotheses were generated following the literature review and in particular followed on from research by Jacobsen & Hofmann (1997) described in the Introduction. These researchers found that, on average, securely attached children achieved higher grades, had better attention, higher levels of
participation and also a more secure sense of self. However, Jacobsen & Hofmann (1997) reported that young people rated as insecure in this study did not go on to develop behavioural problems and they were surprised that no link between attachment and social interest at school was found. They questioned their choice of measures and called for further research which used measures specifically designed to assess attachment, as theirs did not (Jacobsen & Hofmann, 1997). It therefore seemed likely that young people who were refusing to attend school would be likely to have less secure attachment relationships than school attenders.

5.3 The Case Against Attachment Theory

It could be argued that the concept of attachment is not a helpful tool in trying to understand school refusal, since scores of overall attachment to mother and overall attachment to father did not distinguish between refusers and attenders. Indeed, it may be that other factors (such as school factors) described in the Introduction and outlined in table 20 are much more pertinent in the onset/maintenance of school refusal. For example, were school refusers experiencing a general depression and/or anxiety of which refusing to attend school was just one symptom (Egger et al. 2003)? Alternatively, it may be that there are problems at home which maintain school refusal such as, "psychological problems in the parent; family breakdown, separation and divorce; traumatic events at home such as bereavement, violence and abuse; situations where the child is required to look after a younger sibling" Archer et al. (2003, p.14). Young people may be refusing to attend school because they are being bullied there and the school does not have an adequate anti-bullying policy (Archer et al. 2003). Given that the scores of overall attachment to both mother and father did not distinguish between refusers and attenders it seems as though the concept of attachment does little to aid our understanding of school refusal.

In can be argued that, by focusing on attachment, other aspects of relationships with parents and peers which may contribute to school refusal, have been ignored. For example, lack of intimacy and shared positive emotions (Rutter, 1995) may be more considerable relationship contributory factors than attachment in the onset/maintenance of school refusal.
<table>
<thead>
<tr>
<th>Factor</th>
</tr>
</thead>
</table>
| 1 | Child's mental health difficulties, e.g. depression and/or anxiety  
| 2 | Parent's mental health  
| 3 | Family breakdown, separation and divorce  
| 4 | Traumatic events at home such as bereavement  
| 5 | Violence and abuse at home  
| 6 | Staying at home to look after a sibling  
| 7 | Separation anxiety  
| 8 | Family beliefs and experiences (for example, does the family see starting school/transition from Primary to Secondary school as a loss)  
| 9 | Poor communication between school and family  
| 10 | Bullying at school  
| 11 | Transition from Primary to Secondary school  
| 12 | Poor school structures  
| 13 | Reinforcement of behavioural patterns (i.e. initial absences from school are reinforced and absences become more and more frequent)  
| 14 | Poor cognitive, social and emotional development.  
| 15 | Age of mother  
| 16 | Socio economic status  
| 17 | Gender of the child  
| 18 | Family size  
| 19 | Child's level of literacy/numeracy  
| 20 | Peer relationships  
| 21 | Lack of shared positive emotions and intimacy in relationships  

Table 20: Other factors that may influence school refusal/attendance
5.4 The Case for Attachment Theory

Exploration of the significant results highlights the utility of the concept of attachment as a tool to aid our understanding of school refusal. School attenders obtained statistically significantly higher scores on the measure of attachment to peers than school refusers. Refusers may have been less attached to peers because they were seeing less of them, due to their absence from school, in other words, it may simply be a 'consequence' rather than a 'cause' of their school refusal. Whether peer relationships are seen as a 'cause' (trigger/factor in aetiology) or a 'consequence' (and possible maintaining factor) one needs to ask why these refusers had such poor relationships with their peers. Poor relationships with peers could be due to a number of factors, such as poor social skills, however, attachment as a concept can aid our understanding of this situation. It may be that those who have poor relationships with peers have poor internal working models of relationships and thus may be less able to relate to their peers.

The fact that school attenders scored significantly higher than school refusers on the Trust for Father subscale supports this interpretation. According to analytic literature described in the Introduction, fathers can be seen as gatekeepers to the social world and act as a template for future relationships (Steele, 2002; Target & Fonagy, 2001 & Henderson, 1982). If school refusers are unable to trust their fathers it may be that their entry into the social world has not been as smooth as the attenders' entry into the social world and school refusal could be seen as one aspect of this. From a systemic framework, it can be argued that this finding (low levels of trust) suggests that the security of the family base has been undermined (Byng-Hall, 1999). The finding that refusers communicate more with their fathers than attenders seems surprising, in that if young people simply had a poor relationship with their father they would talk to him less. However, Byng-Hall (1999) has argued that the 'secure family base' can be undermined if there is fear of losing an attachment figure. It could be that these school refusers are afraid of losing an attachment figure and are communicating with them as much as possible to try and prevent the loss. As the clinical sample in this study was so small it was impossible to analyse gender differences between girls' and boys' attachments to fathers'.
5.5 Links Between Attachment Theory and Other Factors

The arguments presented above can be criticised for being overly simplistic. The current study indicates that school refusers' attachment relationships with their parents (and the security of their family base) do not differ significantly from those of school attenders. From this it can be speculated that security of attachment does not directly influence school attendance. It is possible that there is a direct relationship but the measure (IPPA) adopted in this study lacked the sensitivity to detect differences between the groups, this is discussed in the limitations/critique section. However, it seems fair to assume that attachment does not appear to have a direct impact on school attendance.

It is hypothesised that attachment may have an indirect affect on school attendance, by interacting with other factors that have been observed to impact school attendance/refusal. In section 5.3 it was argued that attachment theory has nothing to offer the understanding of school refusal and that other factors, listed in table 20 were more useful in making sense of school refusal. This was overly simplistic since the concept of attachment can be seen as embedded within many of the factors listed.

In section 5.3 it was argued that young people may refuse school because they are being bullied and the school lacks an effective anti-bullying policy (Archer et al., 2003). The researcher made some attempt to investigate this possibility by asking participants what they liked and disliked about school, and participants in both groups highlighted that they did not like bullying. However it is impossible to say from the data whether school refusers experienced more bullying than school attenders. Despite this limitation, it is possible to speculate about the utility of applying the concept of attachment to this situation in order to explore why, despite a poor anti-bullying policy several children are able to attend school. From this perspective, it could be argued that those whose bullying leads to school refusal are those who have less secure attachment relationships, and poorer internal working models of relationships and thus would probably be less able to deal with bullying. Furthermore, it could be reasoned that if a bullied individual does not have a secure family base they are less able to cope with the bullying and maintain high self-esteem.
This potential complex relationship between attachment and other factors can be illustrated with another example in which attachment is considered to be embedded with levels of literacy/numeracy. Whilst participants with a learning disability were excluded from the study, no other major attempts were made to 'control' for levels of literacy/numeracy. It could be speculated that school refusers were not attending school because they were struggling and found it frustrating and humiliating to fail. In this context it could be reasoned that attachment is therefore irrelevant, hence the non-significant results obtained in this study. However, it may be that attachment could be seen as one factor among many others (such as genetics, quality of teaching) that determine levels of literacy/numeracy. Since if young people have a secure family base they may have the courage to persevere with school despite their frustrations with learning. This is supported by Jacobsen & Hofmann's (1997) claim that on average, children who were more securely attached to their parents achieved higher grades, had better attention, higher levels of participation.

It can be speculated that factors identified in table 20 interact with each other. As the clinical sample was so small it was not possible to analyse gender differences across the groups. This study also failed to 'control' for parental mental health. However, it can be argued that within many White British households (the majority of the participants came from such families, see the critique/limitation section for more on ethnicity), if a parent had a mental health problem, it may be that a daughter would be more likely to adopt parental care-giving roles in the family than a son and thus could stay at home to look after a sibling or parent, a factor in school refusal (Archer et al. 2003). The concept of attachment, the secure family base can be seen as embedded within these factors and this can enrich our understanding of the scenario. For example, since school refusal has been observed in families with 'parentified scripts', it may be that the daughter in this family is more likely to develop school refusal (Byng-Hall, 2002).

It is possible that when the complexities of attachment theory are appreciated, it can be used as a tool to make sense of situations that seem surprising. For example, if the child is a member of a large, single parent family which has a low socio-economic status it could be argued that these factors all contribute to an increased likelihood of a
young person refusing to attend school. One can speculate that if a child has numerous siblings, one child's absence at school may be overlooked, or a child may be required to stay at home to look after an unwell sibling because the single parent needs to work all hours to financially support the family. However, imagine if this family is coping very well and all the children are attending school. The concept of attachment can be applied to this scenario to enrich our understanding of it. For example, attachment theory draws our attention to the possibility of alternative attachment figures such as grand-parents, aunts and caregivers and that a secure family base will exist as long as the family "provides a reliable and readily available network of attachment relationships and appropriate caregivers from which all members of the family are able to feel sufficiently secure to explore their potential" (Byng-Hall, 1999, p.627).

5.6 Strengths and Difficulties Profiles from Exploratory Analysis

The participants in both groups also completed the SDQ and profiles of school refusers were contrasted with those of school attenders for two reasons. Firstly, it was hoped that this would act as a check that the CAMHS sample, identified by clinicians, did actually meet Heyne et al.'s (2002) criteria (set out in the Introduction) and, secondly, to identify any discrepancies which could present an alternative picture to Heyne et al.'s criteria. It was considered that this second objective was reasonable since all the clinicians were well-qualified and experienced mental health workers (Clinical Psychologists and Community Psychiatric Nurses).

School refusers scored statistically significantly higher Total scores on the SDQ and Emotion, Peer and Conduct subscale scores. The significantly higher Total and Emotion scores are as one would anticipate given Heyne et al.'s criteria. The Emotional subscale on the SDQ measures physical and emotional symptoms of anxiety. Heyne et al.'s (2002) criteria can be summarised as extreme emotional distress or complaints of physical illness when asked to go to school without conduct
disorder. These symptoms result in very long absences from school with the parents' knowledge (Heyne et al., 2002).

The finding that school refusers had statistically significantly higher scores on the Problems with Peers subscale does not seem surprising given that they obtained significantly lower scores on the measure of overall attachment to peers. However, it is surprising that school refusers obtained significantly higher scores on the Conduct subscale of the SDQ. This is not what one would anticipate and seems to be suggestive of truanting behaviour. On the other hand, if the CAMHS sample were truants rather than school refusers, one would anticipate that they would have obtained significantly lower pro-social scores than the attenders. There was no significant difference between the two groups on pro-social scores. Two of the CAMHS sample did seem to differ from the rest of the sample in that they had a history of difficulties with anger, shouting, and, occasionally, fighting. At the stage of recruitment, the researcher and field supervisor discussed the appropriateness of interviewing these two young people. It was decided that the researcher would interview them (assuming consent was obtained, which it was) since the clinicians involved believed that despite a history of minor conduct difficulties, the overall presentation was one of school refusal. Once the results were obtained, an analysis was run again without these two young people and interestingly there was no longer a statistically significant difference in the conduct scores of the refusers and attenders. An analysis of the responses to the conduct subscale questions revealed that these two school refusers scored more highly on two questions in particular, namely, "I get very angry and often lose my temper" and "I fight a lot", when compared to the other school refusers.

In the clinical sample, parents and young people completed the SDQ and no significant differences were found between their scores. It could be argued that this implied perceptions of psychological symptoms were similar. In reviewing the SDQ categorisation data, it did not seem as though school attenders had particularly high needs on the subscales, with the exception of the 19% scoring highly on the 'Problems with Peers' subscale, which could be due to the participants being in the adolescent phase of development (Herbert, 1998). From the rather minimal data, it appears as though the majority of attenders had no psychological problems. The school refusers
did not seem to experience psychological difficulties over and above what one would expect for school refusers (except for conduct problems as described above).

5.7 Limitations/Critique of the Current Study

5.7.i Sample Size
The conclusions drawn from this study are tentative and should be treated with caution because of the relatively small sample size, particularly in the school refusers group. Had this group been larger, the observed power would have been greater and thus it would have been easier to detect any statistically significant differences between the two groups. The small sample size was due to difficulty recruiting school refusers. Some potential participants were refusing to attend the clinic for therapy sessions and did not want to take part in the research, possibly because they did not want to think or talk about school. Future research would benefit from approaching multiple trusts so that school refusers from a greater number of CAMHS teams could be recruited, thus increasing the sample size and power of the study.

5.7.i.b. Siblings
Archer et al. (2003) reported that staying at home to look after a sibling may have been a factor in school refusal. This study failed to examine this possibility. However there is no real evidence that school refusers in this study were staying at home to look after a sibling and a higher proportion of attenders (85%) had siblings at home, compared to refusers (81%).

5.7.i.c. Single Parents
A third of the group were from single parents and the most common reason for this was that father was not at home. When parents separate, the family often adopts a parentification script (Byng-Hall, 2002), children take on parent's roles. Byng-Hall (2002) said that this often happens in cases of school refusal. It would be interesting
to investigate whether these families have parentified scripts and how parents behaved, for example whether they changed their work hours to accommodate (and reinforce) non-attendance at school. Research could be conducted to see whether school refusers from single parent families had particularly less secure attachments to their fathers. If this was found to be the case, it would be unclear whether the less secure attachment and/or the school refusal were due to father's absence. However, given that 25% of refusers and 22% of attenders lived apart from their father it was unlikely that solely the absence of father from the house would lead to an insecure attachment and/or school refusal.

It would also be interesting to find out whether the participants in the sample had other significant attachment figures, especially those whose father lived separately. If school refusers from single parent families with less secure attachments to their father had secure attachments with other adults, (who may have provided secure exploration), the interpretation of the current study's findings would need to be questioned.

5.7.i.d.Socio-economic Status

Berlin & Cassidy (1999, cited in Byng-Hall, 1999) argued that infant-parent security can be affected by: the parents relationship with the grandparents; the marital (partner) relationship between parents; social support from others, and therapeutic relationships. Belsky (1999) reported that although independently these 'risk factors' are enough to make an attachment relationship insecure, when they are combined they can significantly affect the child-parent relationship. For example, if a mother is depressed this would not necessarily affect the child-mother attachment relationship, however if the marital relationship is in conflict and there is no outside social support the child-mother attachment relationship is likely to be affected (Belsky, 1999). It is therefore important to question whether families, particularly those that were single parent families, were under financial strain, since multiple stressors could affect attachment relationships which could contribute to school refusal.
There may be some truth in this argument since firstly, 6% of refusers came from single parent families where the mother was unemployed, compared to only 1% of attenders who came from single parent families where the mother was unemployed. Secondly, although no refusers came from single parent families where the father was unemployed, 18% of refusers came from single parent families where father’s employment status was unknown. In contrast 1% of attenders came from a single parent family where father was unemployed and 5% of attenders came from single parent families where father’s employment status was unknown. These factors (unemployment and single parenthood) may have influenced attachment relationships (Belsky, 1999; Mackey, 2003; Dunn, 1993). However, it could be argued that attachment is not an issue here, these are social factors that have combined to contribute to the onset/maintenance of school refusal. Unknown employment status does not however mean unemployed, these parents may have been in well-paid jobs.

5.7.i.e. Ethnicity

All participants were White British with the exception of one Black British school attender. This reflects the ethnic make up of the region's population where this research was carried out, which is mainly White British. The results of this study cannot legitimately be generalised to young people with other ethnic backgrounds. It could be recommended that further research be carried out in areas of greater ethnic diversity, to identify whether attachment relationships of school refusers differ from school attenders in those of other ethnic backgrounds and cultures. However, the Western bias of attachment theory needs to be acknowledged; the assumptions that underlie the fundamental concepts of the theory are Western, individuation, exploration and autonomy are valued and in other cultures (such as Japan) these "qualities" are not held in such high regard (Rothbaum et al. 2000). As a result, child-rearing practices and infants' behaviour are different from those in Western cultures (Rothbaum et al. 2000). Adopting this Western theory in other cultures can have catastrophic consequences, for example, it can devalue non-Western child-rearing practices, as described in the Introduction (Rothbaum et al. 2000). It has been argued that attachment theory and attachment measures need to be context specific (Rothbaum et al. 2000).
5.7.ii Use of IPPA

The IPPA has not been used with youngsters under 12 before and yet the youngest participant in this study was only 11 years old. However, it was felt that this was appropriate because the researcher read all the questions to the participants and clarified the meaning of any questions that could not be understood. The participants seemed to understand the questions on both measures having only the occasional query about questions on the IPPA which were phrased in a negative way, for example: "I do not get much attention from my mother" (Armsden & Greenberg, 2003). Despite the participants' ability to understand the questions, using the questionnaire with a few children outside the age range for which the measure has been shown to be reliable and valid will have implications for the reliability and validity of this study's findings.

Self-report measures of attachment like the IPPA have been criticised for measuring feelings and behaviours of close adolescent relationships, rather than measuring "working models of early child-parent relationships" like the AAI (George et al., 1984, 1996), (Shaver & Mikulincer, 2002, p.4). Self-report measures have been assumed to differ from the more rigorous AAI (George et al., 1984, 1996) in that "the AAI is thought to provide a fairly direct window into attachment-related unconscious processes whereas the self-report measures are assumed not to do so" (Shaver & Mikulincer, 2002, p.4). Shaver & Mikulincer (2002, p.4) argue that this assumption is false as self report measures are "convenient surface indicators of differences in attachment-related cognitions, emotions and behavioural tendencies which are partly unconscious processes" which can be used "to see whether those processes work the way attachment theory leads us to expect."

Armsden & Greenberg (1987), in designing the IPPA, assumed that the internal working models of attachment figures could be accessed through assessing degree of mutual trust, quality of communication and degree of anger/alienation. It could be argued that the IPPA lacked the sensitivity to detect greater differences between the school attenders and refusers as it was assessing working models of current relationships rather than working models of early child-parent relationships. It would be interesting to see whether similar findings would result from a measure that
accessed early child-parent relationship working models (such as the AAI, George et al., 1984, 1996). It may be that the results would be very similar as Shaver & Mikulincer (2002, p.4) reported "self report measures of attachment in close relationships are related to the AAI coding scales".

Unlike the AAI (George et al., 1984, 1996), the IPPA was not designed to "tap the attachment patterns such as those derived by Ainsworth et al. (1978)" (Crowell, Fraley & Shaver, 1999 p.459). The use of a dimensional measure (IPPA) rather than a typological one can be seen as a relative strength of the current research because the dimensional approach is now widely regarded as preferable (Fraley & Waller 1998).

5.8 Implications of the Study

5.8.i Implications for Therapy

Many of the findings from this study were non-significant, however the fact that school refusers scored significantly lower than school attenders on a measure of trust of fathers indicate that it is possible a young person's relationship with their father may be one factor among many others in the aetiology of school refusal. Although school refusers obtained higher scores than school attenders on the measure of communication with father, they obtained significantly lower scores on a measure of trust of father. Observations of mother-child and father-child interactions suggest that, whilst mothers are often more able to provide a secure base, fathers are typically better at providing secure exploration through sensitive and challenging play (Verschueren & Marcoen, 1999; Grossman et al., 2002) (as explained in the Introduction). Children who did not experience good-enough secure exploration are more likely to display anxious and withdrawn behaviour and Verschueren & Marcoen (1999) concluded that the child-father attachment more accurately predicted anxiety and associated behavioural difficulties than child-mother attachment. The current study lends some initial support to their conclusion in the specific case of school refusal. The current study's findings also provide some initial support for those of Steele (2002) that father-child relationships are associated with the way in which a
young person views their peer relationships, since school refusers in this sample appear to trust their fathers less, have less secure attachment relationships with peers, but similar relationships with their mothers compared to attenders. This research, together with the work of Verschueren & Marcoen (1999) and Steele (2002) indicate that it may be beneficial if fathers are involved in the treatment of school refusal.

Whilst it is common practice for the entire family to be invited to attend initial appointments at CAMHS, the researcher has noticed that, in reality, fathers often get sidelined. Interpretations of the current findings indicate the importance of including both caregivers are present throughout therapy and if the young person is being seen individually, both parents should be seen by a clinician. Duhig, Phares & Birkeland (2002) reported on the advantages of including both parents in therapy and provided suggestions about how to engage fathers in treatment. As noted earlier, they may not be the biological parents and perhaps it is more appropriate to speak of main caregivers. When there is only one main caregiver in the family, it may be useful to include another attachment figure, such as a grandparent, who can fill the role of the father from a developmental perspective and act as a gateway to the social world (Henderson, 1982).

This study also indicates the possible benefit of early interventions with children at a young age so that potential attachment difficulties can be worked on as soon as possible, which would hopefully increase the chances of the pre-schooler to developing healthy relationships with peers. For example, Oxford et al. (2000) recommended a behavioural style of intervention (such as the Webster-Stratton, 1994 approach, cited in Oxford et al., 2000) which aimed to help parents to interact positively with infants and young children to develop secure attachments. It seems as though a child with secure attachments to both caregivers and good relationships with peers might find it easier to attend school and develop secure attachment relationships with peers as they enter adolescence.
5.7.ii Implications at the Service and Government Policy Level

In recent years, there has been a trend towards viewing school refusal as outside CAMHS' remit. The school refusers in this study were recruited from CAMHS services which were reviewing their referral criteria. These services were tightening their criteria in order to manage waiting lists efficiently and reach government targets with regard to waiting times. Since school refusal is not listed in the ICD-10 (World Health Organisation, 1992) and DSM-IV (American Psychiatric Association, 1994) it is possible that young people without a definite 'mental illness' (i.e. with a diagnosis listed in one of the aforementioned classification systems) would not be seen. Furthermore, recent government initiatives which involve fining or sending parents to prison if their child fails to attend school adds to the image of school refusal as a social problem. Whilst to an extent these problems can be seen as social, this research lends support to the notion that school refusal is a psychological difficulty and that the psychological aspects should be treated, as well as possible social elements of the problem.

5.8 Recommendations for Further Research

In the Limitations/critique of the current study section, several recommendations for future research have been made. These relate to using larger sample sizes, use of alternative measures (such as the AAI, George et al., 1984, 1996) and investigations into ethnicity; relationships with siblings and relationships in single parent families. It seems as though this study may have been overly ambitious in attempting to find differences between the attachment relationships of school refusers and school attenders. In this discussion there has been a great deal of speculation about how attachment may interact with other factors to influence school attendance and how attachment can be seen as a concept which is embedded within these factors. It would be useful if future research could test out some of these possible relationships. For example, one could examine the role of attachment in the relationship between bullying and school attendance. An investigation into the experiences of bullied young people could explore what distinguishes bullied children that refuse school from those who continue to attend. A study could be conducted to test whether a
secure family base is correlated with continued school attendance and/or an insecure family base is correlated with school refusal. Another example of a study to investigate some of these hypothesised complex relationships would also be to explore the possible impact of parental mental health on school attendance and consider the utility of attachment theory in making sense of this relationship.

In this discussion, it has been argued that one interpretation of the findings is that school refusers have failed to develop secure relationships with their fathers and, as a result, have struggled to develop relationships with others; peers and teachers, for example. In other words, it is assumed that attachment to the father directly influences attachment to peers and this assumption is based purely on theory (Steele, 2002; Henderson, 1982 and Verschueren & Marcoen, 1999). The current study does not provide causal evidence for this link. In order to establish whether this interpretation of current findings is correct, further research would need to be conducted. It would also be interesting to investigate the potential gender differences between boys' and girls' attachment relationships to their fathers'.
6. Conclusions

The findings did not support the suggestion that school refusing children viewed themselves as less securely attached to their mothers than children attending school. Whilst the findings did not support the notion that school refusing children saw themselves as less securely attached to their fathers in general, school refusers reported significantly lower levels of trust and higher levels of communication with their fathers than school attending participants. The findings supported the notion that school refusing participants viewed themselves as less securely attached to their peers than school attending participants.

Systemic and analytic ideas have been adopted to try and make sense of these findings. From an analytic perspective, it has been argued that the observed lower levels of trust for fathers could be linked to the finding that school refusers obtained lower scores on a measure of overall attachment to peers. If fathers are seen as gatekeepers to the social world and the relationship with the father/secondary caregiver is seen as a basis for future relationships, then a difficult relationship with fathers could lead to a difficult relationship with peers and difficulties entering the social world, including attending school. However, it is acknowledged that this study does not provide evidence for this conceptual link between attachment relationships, it is merely speculative. Furthermore it is unclear from the current study how the relationship with father may be influenced by other factors such as gender, further research is needed to explore such issues.

Within a systemic perspective it has been hypothesised that the observed significant differences in trust and communication could be seen, as an indicator that the 'secure family base' has been undermined in families of school refusers and this may contribute to attendance difficulties. It has been argued that the concept of the secure family base may be embedded within complex relationships between other factors shown to influence school refusal. However this study is limited in its ability to support such hypotheses and further research would be needed to explore these.
Previous research that has highlighted other factors that contribute to school refusal has been presented. The strengths and weaknesses of attachment theory have been clearly outlined. Fundamental weaknesses of the theory include its Western bias and the absence of one clear definition of the internal working model concept. However, it is argued that the notion of attachment derived from attachment theory can be usefully applied in school contexts if viewed as one factor amongst many, which together in their complex interaction influence school attendance and school refusal.
References


APPENDICES
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Appendix 1: NHS Ethical Approval
Dear Ms. Flack-Hill,

REC No: WK033/2/03 A Comparison of School Attendees & Non-attendees Attachment Relationships to their Main Caregiver.

Thank you for your letter dated 6th April 2003 enclosing the following information:

I. Information Sheet for parent/guardian and young person to read, version 2;
II. Consent form for parent/guardian and young person to sign (non-attendees to school);
III. Information Sheet for parent/guardian and young person to read;
IV. Consent form for parent/guardian and young person to sign;
V. Inventory of parent and peer attachment (IPPA);
VI. Ethics application form, version 2.

I am satisfied that you have answered the concerns of the Committee and approve the project as outlined in my letter of 21st March 2003.

Yours sincerely

Miss. Julia Law
Chairman – Maidstone and Tunbridge Wells Research Ethics Committee

cc: R & D Office, West Kent NHS and Social Care Trust
Appendix 2: University Ethical Approval
Dear Ms Flack-Hill

A comparison of school attendees and non-attendees attachment relationships to their main caregiver (ACE/2003/40/Psych) – FAST TRACK

I am writing to inform you that the University Advisory Committee on Ethics has considered the above protocol under its ‘Fast Track’ procedure and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed, and the following condition is met:

- That the fully completed Protocol Cover Sheet, forwarded to you with my letter of 25 April 2003, is returned to me to be placed on the Committee’s records.

For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2003/40/Psych) - Fast Track The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 06 May 2003
Date of expiry of approval by the Advisory Committee on Ethics: 05 May 2008

Contd ....
Please inform me when the research has been completed.

Yours sincerely

\[signature\]

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr J Murray, Supervisor, Dept of Psychology
Ms M McCutcheon, West Kent NHS & Social Care
Appendix 3: Research and Development

Approval
04 November 2003

Ms C Flack-Hill

Dear Ms Flack-Hill

Re: Research Proposal

Your project has been considered by the Research & Clinical Effectiveness Committee and operational approval has been granted.

Please can you inform us of any changes to your project and provide us with a copy of your findings and recommendations.

Good luck with your research.

Yours sincerely

Dr Lona Roberts
Chair - Research & Clinical Effectiveness Committee
Appendix 4: Information sheets
INFORMATION SHEET FOR PARENT/ GUARDIAN AND YOUNG PERSON
TO READ (Non-Attendee's Version)

Project's long title:
A Comparison of School Attendees and Non-Attendees Relationship to their Main Caregiver

Project's short title:
An investigation into the experiences of young people at home and school.

Would you like to take part in this research project? Before answering this question, it is important that you read the following information which describes what the research is about and why it is being carried out. Please feel free to ask any questions and take some time to decide whether or not you wish to take part.

1. **What is the purpose of this study?**

   This study aims to compare the experiences of young people who do attend and those who do not attend school. In doing this it is hoped that we will gain a clearer understanding of the difficulties faced by those who refuse to attend school.

2. **Why have I been chosen?**

   You have been chosen because you do not attend school. You will be one of thirty-two individuals interviewed.

3. **Do I have to take part?**

   It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to show your parents and then to keep. If you decide to take part you are still free to withdraw at any time and without giving any reason. This will not interfere with any help offered by this service.

4. **What will happen to me if I do take part?**

   If you decide to take part you will be invited to talk to the researcher and answer questions about your relationships with other people. This will take up to an hour and will only happen once. Your parent/guardian will need to see this information form, sign the consent form and complete a brief questionnaire.
5. **Is the conversation confidential (private)?**
All information collected about you during the course of the research will be kept strictly confidential. Information collected will have your name and any identifying information removed. It will be kept in a locked cupboard until it is destroyed (within the next five years). The researcher will not feed back to (tell) your parents or teachers what you say during the conversation. If you consent to take part in the research the researchers may look at your medical records for the purpose of analysing the results. Your name will not be disclosed outside of the clinic.

6. **What will happen to the results of the research study?**
The results of all the interviews will be analysed and a report will be written. This report may then be published in an academic magazine. Regardless of whether or not the report is published, information in the report will be anonymous: that means nobody will know it is you.

7. **Who has reviewed the study?**
This study has been reviewed by Maidstone Research Ethics Committee.

8. **Contact for Further Information.**
Further information can be obtained from Charlotte Flack-Hill at Gatland House (01622 723600).
INFORMATION SHEET FOR PARENT/GUARDIAN AND YOUNG PERSON
TO READ (School-Attendee's Version)

Project's long title:
A Comparison of School Attendees and Non-Attendees Relationship to their
Main Caregiver

Project's short title:
An investigation into the experiences of young people at home and school.

Would you like to take part in this research project? Before answering this question, it is important that you read the following information which describes what the research is about and why it is being carried out. Please feel free to ask any questions and take some time to decide whether or not you wish to take part.

1. **What is the purpose of this study?**
This study aims to compare the experiences of young people who do attend and those who do not attend school. In doing this it is hoped that we will gain a clearer understanding of the difficulties faced by those who refuse to attend school.

2. **Why have I been chosen?**
You have been chosen because you regularly attend school. You will be one of thirty-two individuals interviewed.

3. **Do I have to take part?**
It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to show your parents and then to keep. If you decide to take part you are still free to withdraw at any time and without giving any reason.

4. **What will happen to me if I do take part?**
If you decide to take part you will be invited to talk to the researcher and answer questions about your relationships with other people. This will take up to an hour and will only happen once. Your parent/guardian will need to see this information sheet, sign the consent form and complete a brief questionnaire.
5. **Is the conversation confidential (private)?**
All information collected about you during the course of the research will be kept strictly confidential. Information collected will have your name and any identifying information removed and will be kept in a locked cupboard until it is destroyed (within the next five years). The researcher will not feed back to (tell) your parents or teachers what you say during the conversation.

6. **What will happen to the results of the research study?**
The results of all the interviews will be analysed and a report will be written. This report may then be published in an academic magazine. Regardless of whether or not the report is published, information in the report will be anonymous: that means nobody will know it is you.

7. **Who has reviewed the study?**
This study has been reviewed by Maidstone Research Ethics Committee.

8. **Contact for Further Information.**
Further information can be obtained from Charlotte Flack-Hill at Gatland House (01622 723600).
Appendix 5: Consent Forms
CONSENT FORM- FOR PARENT/GUARDIAN AND YOUNG PERSON TO SIGN (School Non-Attendee's version)

Identification number:
Project's long title:  
A Comparison of School Attendees and Non-Attendees Relationship to their Main Caregiver
Project's short title:  
An investigation into the experiences of young people at home and school.

Please tick each box

1. I confirm that I have read and understand the information sheet dated 10.02.03. for the above study and have had the opportunity to ask questions. □

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without my care being affected. □

3. I give permission for the researchers to look at my medical and psychology notes for the purpose of research. □

4. I agree to take part in the above study. □

Name of Young Person Date Signature

Name of Parent/Guardian Date Signature

Researcher Date Signature

Thank you very much for agreeing to take part. You will have a copy of this information and consent form to keep.
CONSENT FORM- FOR PARENT/GUARDIAN AND YOUNG PERSON TO SIGN (School Attendee's version)

Identification number:
Project's long title:
A Comparison of School Attendees and Non-Attendees Relationship to their Main Caregiver

Project's short title:
An investigation into the experiences of young people at home and school.

Please tick each box

1. I confirm that I have read and understand the information sheet dated 10.02.03 for the above study and have had the opportunity to ask questions. □

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. □

3. I agree to take part in the above study. □

Name of Young Person Date Signature

Name of Parent/Guardian Date Signature

Researcher Date Signature

Thank you very much for agreeing to take part. You will have a copy of this information and consent form to keep.
Appendix 6: Interview Schedule
Basic Interview Structure.

**STEP 1:** In waiting room check consent form has been signed by parent and young person and check they are happy to proceed. Check the parent has completed Strengths and Difficulties Questionnaire.

**STEP 2:** In clinic room ask questions 1-3a
General questions before introducing the attachment measure, for descriptive purposes. Comments in brackets are simply notes for the interviewer.

1. Please tell me which one of the following best describes your ethnicity:
   - Black Caribbean □
   - Chinese □
   - Black African □
   - Asian Other □
   - Black British □
   - Bangladeshi □
   - Black Other □
   - Pakistani □
   - Indian □
   - White □

   Any Other please specify: _________________________________________

2. How old are you? Which year are you in at school?

3a. Could you tell me who lives at home? (Clarify whether or not the family is reconstituted and establish whether the terms mother and father are appropriate when administering IPPA and if not which terms should be used instead.)

**STEP 3:** Administer Attachment Inventory.

**STEP 4:** Administer Strengths and Difficulties Questionnaire to young person.

**STEP 5:** Administer the questions below.

3b. Could you tell me something about everyone at home.
   i) Name (annonymise) and relationship e.g. sibling/ mother
   ii) Do they work?
   iii) (If yes) What job do they do?
   iv) Do you know if they went to college (try to get an estimate of when they left school)?
4. Have you missed much school this term? How much time roughly?

5. Have you always/ever attended school easily? – (history of school refusing – how much missed each year.)

6. How do you find school? What do you like about school? What do you dislike about school?

7. Do you have any extra help in the classroom?

8. Have you done your S.A.T.'s? (if yes) How did you get on in your SATs?

**STEP 6:** Let the young person know that I have asked them the questions that I wanted to and ask them if they want to ask me anything.
Appendix 7: Inventory of Parent and Peer Attachment
## INVENTORY OF PARENT AND PEER ATTACHMENT (IPPA)

### Part I

The following statements ask you about your feelings about your mother or the person who has acted as your mother. If you have more than one person acting as your mother (e.g. a natural mother and a step-mother) answer the questions for the one you feel has most influenced you.

Please read each statement and put an 'X' next to the ONE number that tells how true the statement is for you now.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost Never or Never True</th>
<th>Not Very Often True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Almost Always or Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My mother respects my feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>2. I feel my mother does a good job as my mother.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I wish I had a different mother.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. My mother accepts me as I am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I like to get my mother's point of view on things I am concerned about.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I feel it is no use letting my feelings show around my mother.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. My mother can tell when I'm upset about something.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>8. Talking over my problems with my mother makes me feel ashamed or foolish.</td>
<td>1</td>
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<tr>
<td>9. My mother expects too much from me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I get upset easily around my mother.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. I get upset a lot more than my mother knows about.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. When we discuss things, my mother cares about my point of view.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. My mother trusts my judgment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. My mother has her own problems, so I do not bother her with mine.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. My mother helps me to understand myself better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I tell my mother about my problems and troubles.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I feel angry with my mother.</td>
<td>Almost Never or Never True</td>
<td>Not Very Often True</td>
<td>Sometimes True</td>
<td>Often True</td>
<td>Almost Always or Always True</td>
</tr>
<tr>
<td>18. I do not get much attention from my mother.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. My mother helps me to talk about my difficulties.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. My mother understands me.</td>
<td>1</td>
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<td>21. When I am angry about something, my mother tries to be understanding.</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
22. I trust my mother. | 1 | 2 | 3 | 4 | 5 | 6 | 7
---|---|---|---|---|---|---|---
23. My mother doesn't understand what I am going through these days. | 1 | 2 | 3 | 4 | 5 | 6 | 7
24. I can count on my mother when I need to get something off my chest. | 1 | 2 | 3 | 4 | 5 | 6 | 7
25. If my mother knows something is bothering me, she asks me about it. | 1 | 2 | 3 | 4 | 5 | 6 | 7

Part II
This part asks about your feelings about your father, or the man who has acted as your father. If you have more than one person acting as your father (e.g. natural and step-father) answer the question for the one you feel has most influenced you.

<table>
<thead>
<tr>
<th></th>
<th>Almost Never or Never True</th>
<th>Not Very Often True</th>
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<td>1.</td>
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<td>I wish I had a different father.</td>
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<td>4.</td>
<td>My father accepts me as I am.</td>
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| 7. | My father can tell when I'm upset about something. | 1 | 2 | 3 | 4 | 5 | 6 | 7
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22. I trust my father. | 1 | 2 | 3 | 4 | 5

23. My father does not understand what I am going through these days. | 1 | 2 | 3 | 4 | 5

24. I can count on my father when I need to get something off my chest. | 1 | 2 | 3 | 4 | 5

25. If my father knows something is bothering me, he asks me about it. | 1 | 2 | 3 | 4 | 5

---

**Part III**

This part asks about your feelings about your relationships with your close friends.

Please read each statement and circle the **ONE** number that tells how true the statement is for you now.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Almost Never or Never True</th>
<th>Not Very Often True</th>
<th>Sometimes True</th>
<th>Often True</th>
<th>Almost Always or Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I like to get my friend's point of view on things I am concerned about.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. My friends can tell when I'm upset about something.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
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<td>3. When we discuss things, my friends care about my point of view.</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. Talking over my problems with friends makes me feel ashamed or foolish.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I wish I had different friends.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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<td>6. My friends understand me.</td>
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<td>7. My friends encourage me to talk about my difficulties.</td>
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<tr>
<td>8. My friends accept me as I am.</td>
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<tr>
<td>9. I feel the need to be in touch with my friends more often.</td>
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<td>10. My friends do not understand what I am going through these days.</td>
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<tr>
<td>11. I feel alone or apart when I am with my friends.</td>
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<tr>
<td>12. My friends listen to what I have to say.</td>
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<tr>
<td>13. I feel my friends are good friends.</td>
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<tr>
<td>14. My friends are easy to talk to.</td>
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<tr>
<td>15. When I am angry about something, my friends try to understand.</td>
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<tr>
<td>16. My friends help me to understand myself better.</td>
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<td>17. My friends care about how I am feeling.</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>22. I get upset a lot more than my friends know about.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>23. It seems as if my friends are irritated with me for no reason.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>24. I can tell my friends about my problems and troubles.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25. If my friends know something is bothering me, they ask me about it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix 8: Strengths and Difficulties

Questionnaire
For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all the best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

<table>
<thead>
<tr>
<th>Item</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>I try to be nice to other people. I care about their feelings</td>
<td></td>
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<td></td>
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<tr>
<td>I am restless. I cannot stay still for long</td>
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<tr>
<td>I get a lot of headaches, stomach-aches or sickness</td>
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<tr>
<td>I usually share with others (food, games, pens etc.)</td>
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<tr>
<td>I get very angry and often lose my temper</td>
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<tr>
<td>I am usually on my own. I generally play alone or keep to myself</td>
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<tr>
<td>I usually do as I am told</td>
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<tr>
<td>I worry a lot</td>
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<tr>
<td>I am helpful if someone is hurt, upset or feeling ill</td>
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<tr>
<td>I am constantly fidgeting or squirming</td>
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<tr>
<td>I have one good friend or more</td>
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<tr>
<td>I fight a lot. I can make other people do what I want</td>
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<td></td>
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<tr>
<td>I am often unhappy, down-hearted or tearful</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Other people my age generally like me</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I am easily distracted, I find it difficult to concentrate</td>
<td></td>
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<tr>
<td>I am nervous in new situations. I easily lose confidence</td>
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<tr>
<td>I am kind to younger children</td>
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<tr>
<td>I am often accused of lying or cheating</td>
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<tr>
<td>Other children or young people pick on me or bully me</td>
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<tr>
<td>I often volunteer to help others (parents, teachers, children)</td>
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<tr>
<td>I think before I do things</td>
<td></td>
<td></td>
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<tr>
<td>I take things that are not mine from home, school or elsewhere</td>
<td></td>
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<tr>
<td>I get on better with adults than with people my own age</td>
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<tr>
<td>I have many fears, I am easily scared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I finish the work I'm doing. My attention is good</td>
<td></td>
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</tbody>
</table>

Your Name

Date of Birth

Male/Female

<table>
<thead>
<tr>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
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<tbody>
<tr>
<td></td>
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Thank you very much for your help.

Today's date

284
For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft. Please give your answers on the basis of the child's behavior over the last six months or this school year.

| Child's Name ............................................................... | Male/Female |
| Date of Birth .............................................................. | Not True | Somewhat True | Certainly True |
| Considerate of other people's feelings | ☐ | ☐ | ☐ |
| Restless, overactive, cannot stay still for long | ☐ | ☐ | ☐ |
| Often complains of headaches, stomach-aches or sickness | ☐ | ☐ | ☐ |
| Shares readily with other children (treats, toys, pencils etc) | ☐ | ☐ | ☐ |
| Often has temper tantrums or hot tempers | ☐ | ☐ | ☐ |
| Rather solitary, tends to play alone | ☐ | ☐ | ☐ |
| Generally obedient, usually does what adults request | ☐ | ☐ | ☐ |
| Many worries, often seems worried | ☐ | ☐ | ☐ |
| Helpful if someone is hurt, upset or feeling ill | ☐ | ☐ | ☐ |
| Constantly fidgeting or squirming | ☐ | ☐ | ☐ |
| Has at least one good friend | ☐ | ☐ | ☐ |
| Often fights with other children or bullies them | ☐ | ☐ | ☐ |
| Often unhappy, down-hearted or tearful | ☐ | ☐ | ☐ |
| Generally liked by other children | ☐ | ☐ | ☐ |
| Easily distracted, concentration wanders | ☐ | ☐ | ☐ |
| Nervous or clingy in new situations, easily loses confidence | ☐ | ☐ | ☐ |
| Kind to younger children | ☐ | ☐ | ☐ |
| Often lies or cheats | ☐ | ☐ | ☐ |
| Picked on or bullied by other children | ☐ | ☐ | ☐ |
| Often volunteers to help others (parents, teachers, other children) | ☐ | ☐ | ☐ |
| Thinks things out before acting | ☐ | ☐ | ☐ |
| Steals from home, school or elsewhere | ☐ | ☐ | ☐ |
| Gets on better with adults than with other children | ☐ | ☐ | ☐ |
| Many fears, easily scared | ☐ | ☐ | ☐ |
| Sees tasks through to the end, good attention span | ☐ | ☐ | ☐ |

Signature

Date

Parent/Teacher/Other (please specify)

Thank you very much for your help.
Appendix 9: Listed Occupations' of parents, reported by participants
### Parental Occupations of the School Attendees

<table>
<thead>
<tr>
<th>Mothers</th>
<th>Fathers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountant (x3)</td>
<td>Pipe fitter</td>
</tr>
<tr>
<td>&quot;Odd jobs&quot;</td>
<td>&quot;Don't know&quot; (x4)</td>
</tr>
<tr>
<td>Pensions</td>
<td>Manager (x7)</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>Planning Consultancy</td>
</tr>
<tr>
<td>Sales Director</td>
<td>Mechanic (x3)</td>
</tr>
<tr>
<td>Nail technician</td>
<td>Owns a Business</td>
</tr>
<tr>
<td>Massage Business</td>
<td>University Lecturer</td>
</tr>
<tr>
<td>Beauty Therapist</td>
<td>Chiropractor</td>
</tr>
<tr>
<td>Community Liaison Manager</td>
<td>Sales Manager</td>
</tr>
<tr>
<td>Nursey Nurse</td>
<td>Postman</td>
</tr>
<tr>
<td>Environmental</td>
<td>Supplier</td>
</tr>
<tr>
<td>Finance</td>
<td>Plumber (x2)</td>
</tr>
<tr>
<td>Functions co-ordinator</td>
<td>Probation Officer</td>
</tr>
<tr>
<td>Dinner lady</td>
<td>TV director</td>
</tr>
<tr>
<td>Speech and Language Therapist</td>
<td>Delivers flowers</td>
</tr>
<tr>
<td>Home Office</td>
<td>Night Supervisor</td>
</tr>
<tr>
<td>&quot;At home&quot; (x14)</td>
<td>Worker in Pharmaceutical Company</td>
</tr>
<tr>
<td>Training to be a midwife</td>
<td>Sales</td>
</tr>
<tr>
<td>Intensive Care Nurse</td>
<td>Policeman</td>
</tr>
<tr>
<td>School Secretary</td>
<td>Engineer (x5)</td>
</tr>
<tr>
<td>Sales Administer</td>
<td>Banker (x5)</td>
</tr>
<tr>
<td>Bank and play school</td>
<td>Teacher</td>
</tr>
<tr>
<td>Teacher (x6)</td>
<td>Brewery worker.</td>
</tr>
<tr>
<td>Cleaner (x2)</td>
<td>Tarmacing</td>
</tr>
<tr>
<td>Office Work</td>
<td>Electrician (x2)</td>
</tr>
<tr>
<td>Cook at school</td>
<td>Unemployed (x3)</td>
</tr>
<tr>
<td>Carer</td>
<td>Double glazing</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>Works from home</td>
</tr>
<tr>
<td><strong>Mothers</strong></td>
<td><strong>Fathers</strong></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Computer Deliveries</td>
<td>Factory Worker (x3)</td>
</tr>
<tr>
<td>Nurse</td>
<td>&quot;At home&quot;</td>
</tr>
<tr>
<td>Learning Support Assistant (x2)</td>
<td>Paramedic</td>
</tr>
<tr>
<td>Training to be a counsellor</td>
<td>Handyman</td>
</tr>
<tr>
<td>Doctor</td>
<td>Fire Fighter</td>
</tr>
<tr>
<td>Secretary</td>
<td>Doctor</td>
</tr>
<tr>
<td>Shop worker (x3)</td>
<td>Lawyer</td>
</tr>
<tr>
<td>Web Designer</td>
<td>Financial Advisor (x3)</td>
</tr>
<tr>
<td>Health Care Assistant (x2)</td>
<td>Pensions Specialist</td>
</tr>
<tr>
<td>Charity Fundraiser</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th><strong>Mothers</strong></th>
<th><strong>Fathers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher</td>
<td>Insurance</td>
</tr>
<tr>
<td>Learning Support Assistant (x2)</td>
<td>Sales</td>
</tr>
<tr>
<td>Cleaner (x2)</td>
<td>Builder (x2)</td>
</tr>
<tr>
<td>Carer</td>
<td>Painter and decorator</td>
</tr>
<tr>
<td>&quot;At home&quot; (x2)</td>
<td>Pharmaceuticals</td>
</tr>
<tr>
<td>Gardener</td>
<td>Don't know (x2)</td>
</tr>
<tr>
<td>Dinner lady</td>
<td>Gardener</td>
</tr>
<tr>
<td>Ironing</td>
<td>Manager (x2)</td>
</tr>
<tr>
<td>Shop worker (2)</td>
<td>Driver</td>
</tr>
<tr>
<td>IT software engineer</td>
<td>IT hardware engineer</td>
</tr>
<tr>
<td>Unemployed</td>
<td>Unemployed</td>
</tr>
<tr>
<td>Finance</td>
<td>Manager (x2)</td>
</tr>
</tbody>
</table>